OPERATIVE REPORT

Surgical CAPD Regional

Candidate Inpatient Procedure

Account #: 78904
Patient Name: John Smith
MRN: 6789
Sex: Male
Date of Birth: 09/09/1956
Proceduralist/Surgeon: John Williams , Orthopaedic

Date of Procedure: 04/26/2016
Consulting Provider: Lucian Newman

Assistant: Ben Casey, M.D.

INDICATIONS:

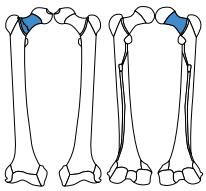
John Smith is a 59 year old year old Male with severe unremitting hip pain secondary to Fracture of femur who has failed conservative treatments.

Preoperatively, the indications for the primary total hip arthroplasty, nature of this procedure, its expected results and potential risks and complications, and alternative methods of treatment were reviewed in length and detail with the patient on multiple occasions. The patient understood those risks and elected to proceed.

PRE-OPERATIVE DIAGNOSES:

Fracture of femur

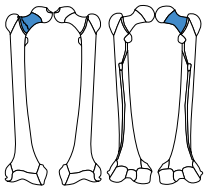
- Head and neck; Neck, base; Displaced, right; Initial encounter, closed fracture
- Location(s): Right Neck



POST-OPERATIVE DIAGNOSES:

Fracture of femur

- Head and neck; Neck, base; Displaced, right; Initial encounter, closed fracture
- Location(s): Right Neck



PROCEDURE PERFORMED:

Total hip arthroplasty, acetabular and proximal femoral prosthetic replacement

- Right Side
- Component Material(s): Metal on Polyethylene
- Cemented
- without Graft

FINDINGS:

Displaced Femoral neck fracture
Bone on bone hip

TECHNIQUE

John Smith was taken to the operating room and after induction of the anesthetic the right hip was prepped and draped in a routine sterile fashion.

Curvilinear incision was made from the anterior lateral approach and carried deep through skin and subcutaneous tissue. Iliotibial bend was divided one fingerbreadth posterior to the insertion of the tensor fascia lata and relaxed slightly posteriorly. The gluteus minimus tendon was identified, tagged, and released. Anterior capsulotomy was completed. Once the capsule was removed and the former capsulotomy was completed, the femoral neck was cut approximately one fingerbreadth proximal to the lesser trochanter. Femoral neck and head were removed using a corkscrew device. Right angle clamp was used to divide the posterior hip capsule and external rotators including the piriformis tendon to allow for exposure of the acetabulum. Acetabular retractor was placed, as was the anterior column retractor of the pelvis allowing for excellent exposure to the acetabulum. The capsular exertion on the acetabulum was removed circumferentially.

We then medial reamed with a reamer and increased our reaming.

A right Medical Dynasty PC shell was inserted and was fixed with a single 25-mmscrew. The Dynasty A-class poly liner was then inserted. We then repositioned the leg and redirected our attention to the femur. We sequentially broached and ultimately finished with a lateralized Provident Hip Stem from StelKast and utilized a Metal on Polyethylene short head. Estimated blood loss was 20 mL . We trialed all components. Once we were satisfied with the trial components on the femoral side, the permanent components were Cemented.

We then thoroughly irrigated. A 1/8-inch drain was placed and the wound was closed and layered in the usual fashion.

ANESTHESIA:

General

COMPLICATIONS:

None

ESTIMATED BLOOD LOSS:

20 mL

SPECIMENS REMOVED:

Femoral head and neck were discarded

IMPLANTS:

Pinnacle Gription acetabular shell, Sector, 50 mm outside diameter.

Corail cementless femoral stem, KHO, size 11, high offset, collarless stem.

ASSISTANTS:

Ben Casey, M.D.

RISK FACTORS

CURRENT CONDITIONS:

Diabetes mellitus

- Type 2 diabetes mellitus; With kidney complications; Diabetic chronic disease

BODY MASS INDEX:

BMI: 41.6
Height: 190.5cm
Weight: 151.05kg

Electronically signed by
John Williams , Orthopaedic
04/26/2016 12:03 CDT

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CC:

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