

PREOPERATIVE DIAGNOSES:

1. Chronic _____ lateral epicondylitis.
2. _____ elbow lateral common extensor tear with lateral ulnar collateral ligament tearing.
3. _____ elbow cubital tunnel syndrome.

POSTOPERATIVE DIAGNOSES:

1. Chronic _____ lateral epicondylitis.
2. _____ elbow lateral common extensor tear with lateral ulnar collateral ligament tearing.
3. _____ elbow cubital tunnel syndrome.

PROCEDURES PERFORMED:

1. _____ lateral epicondylar debridement with common extensor repair with platelet-rich fibrin membrane, 24359.
2. _____ elbow lateral ulnar collateral ligament repair, 24345.
3. _____ elbow cubital tunnel release, 64718.

FIRST ASSISTANT: Andie Divita, Physician Assistant. Please note that a physician assistant as a surgical assist was necessary in critical for procedure being performed. The procedure could not be performed without her presence. She was in role with retractor holding, position the limb to allow its access and exposure for appropriate decompression as well as epicondylar debridement.

ANESTHESIA: General with local liposomal bupivacaine infiltrated at surgical site.

COMPLICATIONS: None apparent.

ESTIMATED BLOOD LOSS: Less than 30 mL.

TOURNIQUET TIME: Approximately 45 minutes.

IMPLANTS:

1. Arthrex FiberTak All-Suture anchor x1.
2. MTF platelet-rich fibrin membrane x1.

BRIEF INDICATIONS FOR PROCEDURE:

Because of the combination of symptoms and failure to improve with conservative measures, we discussed with the patient that we could go in and address both problems at the same time. Consent was obtained from the outpatient setting. The patient

expressed understanding of the risks, benefits, potential complications, outcomes, and elected to proceed.

DESCRIPTION OF PROCEDURE: The patient was seen in the preoperative holding area. The _____ elbow was marked and confirmed with the surgical consent. We then drew approximately 30 mL of whole blood to be used in preparation for the platelet-rich fibrin membrane. The patient was then taken back to the operative suite and placed supine on the operating table and general anesthesia was induced by the Anesthesia team. The tourniquet was applied to the _____ upper brachium. The _____ upper extremity was then prepped and draped in the standard sterile fashion and draped over an armboard. A time-out was performed and confirmed with all parties involved including the surgical consent and the preoperative mark. Once this was done, we then marked out our planned surgical incisions. We first began by doing the cubital tunnel release. An Esmarch was used to exsanguinate the limb and the tourniquet was taken up to 250 mmHg. The patient did have a large amount of subcutaneous fat because of her obese history. We marked out this planned surgical incision. We then infiltrated the local subcutaneous tissues with Marcaine with epinephrine for localized hemostasis. A 15-blade was then used to make an incision along the medial aspect of the elbow just posterior to the medial epicondyle and anterior to the olecranon process. This was approximately 8-mm curvilinear incision. We carried this down through the subcutaneous planes. Blunt retractors were then used. We then identified the medial epicondyle as well as the cubital tunnel. We were easily able to palpate the ulnar nerve lying within this tunnel. Then, using blunt dissection, we opened up Osborne fascia and ligament and we were able to easily visualize the constriction of the ulnar nerve within the cubital tunnel. We then released distally releasing the ligament of Struthers as well as between the two heads of the flexor carpi ulnaris to free up the ulnar nerve distally. We then moved our way proximally taking great care to stay above the nerve and to keep it within our visual field at all times. The cubital tunnel was then completely released. We then released proximally. The elbow was then taken through the range of motion and the nerve was found to be nice and free without any signs of subluxation or instability within the cubital tunnel. Once this was done, we then copiously irrigated this wound. We infiltrated the subcutaneous tissues with liposomal bupivacaine for anesthetic. We then loosely close the deep layers with 2-0 Monocryl inverted mattress fashion.

We then turned our attention to the lateral aspect of the procedure for the lateral epicondylar debridement. We then made an oblique incision beginning just proximal to the lateral epicondyle extending 3 cm distally. The incision was carried down through the skin to the subcutaneous fat. Large soft tissue planes were elevated so that we could evaluate the decussation between the EDC aponeurosis and a common extensor. Then, staying in the anterior half of the lateral epicondyle, we used an inside blade to make a curvilinear incision at the decussation between the EDC and ECRB. This was taken all the way down to the bone of the lateral epicondyle. Once this was done, we were able to evaluate the lateral epicondyle, which did have some deep to the extensor carpi radialis longus. We did evaluate the ECRB tendinous attachment at its anterior half. It did have trophic findings and opacity of the tissue consistent with Nertial criteria. This was debrided off the undersurface of the ECRB and ECRL and was found to have some cystic changes on the lateral epicondyle at its attachments. Once this was done, we used a curette as well as a rongeur to gently decorticate the lateral epicondyle and created a bony bed for healing and bleeding. We then used an Arthrex FiberTak anchor x1. This was then used through the drill guide and then the anchor was placed into its footprint. We then tensioned this to allow deployment of the anchor interosseous. The two limbs of the FiberTak anchor were then used to run the PRP membrane down to the footprint, which had been previously prepared and send on the suture to the footprint. Once this was done, we then used a modified Lachman stitch to compress the tendinous attachment on the footprint down to perform our common extensor repair as well as lateral ulnar collateral ligament repair down to the footprint on the lateral epicondyle. We then copiously irrigated the wound with liposomal bupivacaine mixed with Marcaine was used to infiltrate the soft tissues. A 2-0 Vicryl was then used to repair the remainder of the fascial split. We then used 3-0 Monocryl to close the deep dermal layer and a running 3-0 Monocryl subcuticular suture. The wound was then dressed with Mastisol, Steri-Strips, 4x4s, and ABD. The patient was placed in a long posterior splint from the brachium to the metacarpophalangeal joints. The tourniquet was let down. The patient was then awoken and transferred to the recovery room in a stable condition.