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PREOPERATIVE DIAGNOSES: Peroneal tendon tear, left foot.

POSTOPERATIVE DIAGNOSIS: Peroneal brevis tendon tear.

PROCEDURE: Peroneal brevis tendon repair, left ankle.

PATHOLOGY: None.

ANESTHESIA: General with local.

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HEMOSTASIS: Thigh tourniquet at 300 mmHg.

ESTIMATED BLOOD LOSS: 25 mL.

COMPLICATIONS: None.

MATERIALS: 4-0 Prolene. An amniotic tissue layer.

INDICATIONS: Please see H&P.

FINDINGS: Please see below.

DESCRIPTION OF PROCEDURE: After informed consent was obtained from the patient, the patient was brought to the operating room, placed on operating table in a partial lateral decubitus position. A preop block was then performed utilizing 0.5% Marcaine. The left lower extremity was then cleaned, prepped and draped in usual aseptic manner. The left lower extremity was then elevated before a pneumatic tourniquet was inflated to 300 mmHg.

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Next, an incision was made just posterior to the fibula extending down to the base of the 5th metatarsal in a curvilinear fashion. Blunt dissection was then performed. All vital structures were identified and retracted. All bleeders were identified, ligated and cauterized as necessary. Next, the sural nerve was identified and was retracted plantarly and posteriorly. Next, the tendon sheath was then opened up. Increased fluid was noted to be within the tendon sheaths. Next, the tendon sheath was then extended distally and 2 separate sheaths were then opened up for the peroneal brevis tendon as well as the peroneal longus tendon. Next, the peroneal brevis tendon was inspected and a small 3.5 cm tear was noted. The peroneal longus tendon was noted to be intact and within normal limits. The peroneal brevis tendon was then scraped utilizing a curette. Next, the tear was then repaired utilizing 4-0 Prolene in a tubular fashion. Next, the peroneal brevis tear was then wrapped utilizing a 3 x 3 amniotic tissue layer. The incision was then flushed with copious amounts of normal sterile saline. The tendon sheaths were then closed in typical fashion. Next, the skin was then closed in typical layered fashion. The pneumatic tourniquet was deflated and a prompt hyperemic response was noted to all digits of the left foot. A dry sterile dressing was applied consisting of Adaptic, 4 x 4s, Kerlix and ACE bandage. The patient was then placed in a posterior splint, consisting of multiple layers of Webril, a 4 x 30 inch fiberglass splint and multiple layers of ACE bandages. The patient was taken to the recovery room with vital signs stable and vascular status intact to the left foot. The patient will remain nonweightbearing and follow up in the office in 2 weeks.

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