DATE OF BIRTH
12/12/52

DATE OF ADMISSION
3/24/92

CHIEF COMPLAINT
Left knee pain and catching sensation.

HISTORY
This is a 39 year old gentleman who on April 4, 1990 fell in a post hole that was under water. He states he fell forward twisting his left knee and had immediate pain. The pain was mostly along the medial side. He was able to stand and ambulate and was seen by Vinewood Family Practice. He was treated conservatively. He continued to have the symptomatology. The pain was medial and posterior when standing and walking a significant amount of time. He had difficulty with standing from a squatting position and feels a catching sensation in addition to the pain. There was no definite locking or giving way.

The patient failed to respond to conservative treatment including anti-inflammatories and physical therapy. Thus, after a long contemplation an MRI scan was obtained. This revealed a comminuted tear of the posterior horn of the medial meniscus. The patient thus was given risks, benefits and alternatives and he has opted for arthroscopic intervention.

PAST MEDICAL HISTORY:
Significant for right knee arthroscopy several years ago. He has an allergy to **CODEINE** which causes some gastric upset. He takes prn Feldene. He has no definite medical illness.

FAMILY HISTORY:
The patient's father is a diabetic, otherwise negative.

SOCIAL HISTORY:
The patient does not smoke or drink.

REVIEW OF SYSTEMS
Negative except for above.

PHYSICAL EXAMINATION
Height 6' 0". Weight 218 pounds. BP 130/90, temp 97, pulse 76, respirations 16.

Continued . . .

HEAD AND NECK: Negative.

CHEST: Clear.

HEART: Regular rhythm.

ABDOMEN: Soft and nontender.

EXTREMITIES: The patient has no definite effusion. Range of motion is full. His patellar grind and apprehension test are negative. His Lochman test is negative. There is a 2+ posterior drawer sign as well as a posterior sag sign. He has 2+ opening to valgus but there is a good end point. There is no instability to varus. Pivot shift is negative. McMurray's reveals pain posteromedially. Neurovascular status is intact.

X-RAYS
Views of the left knee were negative. MRI scan did reveal the posterior horn tear of the medial meniscus.

IMPRESSION:
1. Tear posterior horn medial meniscus.
2. Grade II tear to the medial collateral ligament.
3. Grade II tear posterior cruciate ligament.

PLAN:
Risks, benefits and alternatives were discussed with the patient including the risk of infection, neurovascular injury, persistent pain, loss of motion, deep venous thrombosis, anesthetic reaction, possible recurrent tear and possible inability to completely relieve all pain. The patient understands, he wishes to proceed with the surgery. We will do so on 3/24/92.

DWK:sd
cc: Dr. Ed Freund
DD: 03/19/92
DT: 03/19/92
#7292

DARRYL W. KITAYAMA, M.D.

DATE OF OPERATION
3-23-92

PREOPERATIVE DIAGNOSIS
Tear posterior horn medial meniscus.
Grade II tear posterior cruciate ligament.

POSTOPERATIVE DIAGNOSIS
Comminuted tear posterior horn medial meniscus.
Medial plica.
Grade II chondromalacia medial femoral condyle.
Tear posterior cruciate ligament - old.

PROCEDURE
Diagnostic arthroscopy.
Arthroscopic partial medial meniscectomy.
Resection medial plica.

SURGEON
DARRYL W. KITAYAMA, M.D.

ASSISTANT: GARY WISNER, M.D.

ANESTHESIA
General endotracheal, Gil Camaya, M.D.

Estimated blood loss: Nil.

Tourniquet time: None.

OPERATIVE TECHNIQUE:
With the patient in the spinal position and under perioperative Rocephin, the patient underwent general endotracheal anesthesia. The patient's extremity was examined and revealed laxity to posterior drawer as well as the posterior sag, Lachman's and anterior drawer were negative. There was mild looseness to valgus.

The right lower extremity was prepped with DuraPrep and draped in the usual sterile fashion. A superior medial portal was established and the knee distended with saline and anterolateral portal was established and the arthroscope inserted.

Under direct visualization an anteromedial portal was established and

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the arthroscopic probe inserted. A diagnostic arthroscopy was then performed. This revealed a large medial plica which had an underlying area of chondromalacia of the adjoining medial femoral condyle. There was no pathology noted of the patellofemoral joint, tracking appeared normal. Examination of the medial compartment revealed Grade II chondromalacia changes of the medial femoral condyle. There was as large flap of the posterior medial horn as well as a complex comminuted tear of the posterior horn medial meniscus. The examination of the anterior cruciate ligaments revealed this to be intact. Examination of the lateral compartment revealed an intact lateral compartment. The lateral meniscus was probed in its entirety and no pathology was noted.

Through the anterior medial portal the upcutting basket resector was used to remove the flap and to debride the comminuted tear to a stable, non-pathologic area. This required resecting approximately 60 to 70 percent of the inner margin of the posterior horn medial meniscus. The edges were then contoured with a 4.0 meniscus shaver. The probe was reinserted and excellent stability and contour was seen.

Attention was then turned to the medial plica where an angle of the resector was used to debride this medial plica. The 4.0 shaver was then used to smooth the edges.

A 70 degree spoke was turned posteriorly and attempt was made to encounter the posterior cruciate ligament. This could not be encountered and thus, it was felt that this was chronically deficient.

The operative field was then irrigated with copious amounts of saline. The portals were infiltrated with .5% Marcaine without Epinephrine. An intra-articular injection of 10 cc of .5% Marcaine without Epinephrine was then performed. The skin was reapproximated with 5-0 nylon. Sponge and needle count was correct. There were no complications, and the patient left the operating room in stable condition.

DWK: hr

DD: 03/24/92
DT: 03/24/92
#8041

DARRYL W. KITAYAMA, M.D.