CASE INFORMATION SHEET

Cases must be received at the Board office along with all of the other portfolio components. If you want to confirm delivery, please use UPS/FedEx which has a tracking number or the USPS with delivery confirmation – Do not call the office to confirm delivery. Please send to following address:

[redacted]

Questions about submitting cases should be directed to the board's Administrative offices, 9 am - 5 pm EST 1-888-852-1442 or you may email us at abmsp@abmsp.org.

SUBMITTING PODIATRIST:

NAME _____

RETURN ADDRESS _____

CITY _____ STATE _____

TELEPHONE (_____ FAX (_____

DATE SUBMITTED 9-17-19

☐ **I have a signed HIPAA form from all of the patient(s) whose case(s) is/are submitted herein.**
↳ * All identifying info is removed *

☑ **I would like my case(s) returned back to me. A $50 check or money order is enclosed payable to ABMSP.**

Cases submitted without a return request and fee will be destroyed. No Exceptions will be made. CC info given via phone 9/17/19

CASE NUMBER	CASE CATEGORY	DATE OF INITIAL TREATMENT
1. 1039494	Soft Tissue	9-4-2018
2. 1020160	Soft Tissue	1-9-2019
3. 24194	Soft Tissue	2-5-2019
4. 1071822	Bone	5-31-2017
5. 1043405	Bone	12-18-2018
6. 22278	Bone	10-18-2018
7. 1012002	Bone	1-21-2019
8. 1083438	Bone	11-6-2018

Office Use Only:

1. A R _____ Sign _____ Date

Notes:

2. A R _____ Sign _____ Date

Notes:

SOFT TISSUE CASE EXAMPLE

PATIENT NAME: [redacted]
DATE OF BIRTH:
PROVIDER:
DATE OF VISIT: 9/7/2019
CLINIC ID NUMBER: 1020160

CASE HISTORY REPORT COVER PAGE FOR

Case Report Number: 1020160

Category: Soft tissue.

Condition Treated: Nonhealing diabetic foot ulceration, second toe, right foot with osteomyelitis.

Patient Age: 83

Initial Date of Treatment: 01/09/2019

Date of Surgery: 02/14/2019

Chief Complaint: (History/duration/prior treatment): The patient is an 82-year-old male with a history of diabetes mellitus and neuropathy and is in hospice care who presented with swelling, redness and an ulceration of the second toe of the right foot. He was seen by his primary care physician who referred him to me. He ultimately was assessed on MRI with positive findings of osteomyelitis and based on the partially reducible contracture of the digit, a percutaneous flexor tenotomy was offered.

Medications: Amlodipine, metformin, Lantus, and tamsulosin hydrochloride.

Exam Findings: Partially reducible second toe, right foot with appearance of cellulitis, ulceration at the distal aspect noted. A hammertoe mallet deformity identified. The digit was erythematous and had a cellulitic appearance. He has reduced sensation consistent with neuropathy and thready pedal pulses. Although x-rays were negative, MRI findings were positive for bone changes.

Assessment/Diagnoses: Distal clavi ulceration with cellulitis, second toe, right foot, complicating factors of diabetes mellitus, mild peripheral arterial disease, osteomyelitis and patient in hospice.

Outcome/Complications: Ultimately, the patient's ulceration healed completely and he required no further intervention, being discharged on 07/10/2019.

DD: 09/07/2019 10:37:04 AM DT: 09/08/2019 10:51:00 PM

PATIENT NAME: [redacted]
DATE OF BIRTH:
PROVIDER:
DATE OF VISIT: 01/09/2019
CLINIC ID NUMBER: 1020160

REASON FOR VISIT
Right foot wound.

HISTORY OF PRESENT ILLNESS
The patient is well known to me, an 82-year-old male. He has a history of diabetes mellitus and neuropathy. He is presently in Hospice. He presents today with a chief complaint of worsening of swelling (without pain) in the right foot. He was treated previously for a similar wound after a similar presentation with a soft tissue correction of the 3rd toe after multiple bouts of antibiotics. He denies fevers, chills, nausea, vomiting, systemic evidence of infection. He is here today with his wife. He was seen by [redacted] yesterday who provided no treatment knowing he was coming today. He indicates he has not been wearing his diabetic shoes because he has had swelling and has been in a nontherapeutic sandal.

PFSH/REVIEW OF SYSTEMS
Read, reviewed, signed, updated today by me.

PHYSICAL EXAMINATION
Constitutional: Well-developed male. Alert, oriented, communicative, pleasant. He ambulates with the walker in somewhat of a shuffling gait. He is in a sandal.

Right Foot Exam: Stable neurovascular status with excellent tissue perfusion and somewhat palpable pedal pulses. There is a hemorrhagic callus in the sub-1 area but of greater concern, distal clavi ulceration, 2nd digit right foot with cellulitic appearance. Drainage is scant. The digit is mildly contracted and has partially reducible hammertoe/mallet deformity. Photograph of the wound was taken. It is full thickness and measures 1.5 cm x 1 cm. There is no lymphangitis or streaking observed.

DIAGNOSTIC READINGS & INTERPRETATION
X-rays taken today, 3 views standing of the right foot, AP, lateral and oblique fail to reveal any acute fracture, dislocation. No bony destructive lesion or gas in the tissue.

CLINICAL IMPRESSION

1. Distal clavi ulceration, right foot.
2. Cellulitis, 2nd toe, right foot.
3. Diabetic ulceration, 2nd toe, right foot due to digital contracture.
4. High risk for limb loss.
5. Compliance gap.

TREATMENT PLAN

1. I have underscored with him the importance of daily inspection and if he is unable to do so himself, he has agreed to this by his wife. We have reiterated the diabetic instructions and diabetes education and informed consent again provided.
2. Empiric doxycycline provided.
3. The wound was debrided and Bactroban ointment applied.
4. He has agreed to use the insert from his diabetic shoe in the surgical shoe previously provided.
5. Change of wound dressing will be today, Prisma and bandage.
6. I will see him back on Monday or Tuesday.

PATIENT NAME: [redacted]
DATE OF BIRTH:
PROVIDER:
DATE OF VISIT: 01/14/2019
CLINIC ID NUMBER: 1020160

REASON FOR VISIT
Right foot.

HISTORY OF PRESENT ILLNESS
The patient is here today for continued management of the 2nd toe right foot. He is tolerating the doxycycline well. He has seen some improvement. He is using the insert in his shoes as was requested.

PFSH/REVIEW OF SYSTEMS
Read, reviewed, without interval change from 01/09/2019 visit.

PHYSICAL EXAMINATION
Constitutional: Well-developed male. Alert, oriented, communicative, pleasant. Ambulation pattern is at baseline. He is here with his wife.

Right Foot Exam: There is consolidation of the erythema to the 2nd digit. Still somewhat erythematous. The wound site is improved. It is not as deep. It is more dry. Photograph of this site was taken.

DIAGNOSTIC READINGS & INTERPRETATION
Lab from Flagler indicates normal skin flora, although clinically, this is somewhat more than the above.

CLINICAL IMPRESSION

1. Cellulitis, 2nd toe, right foot.
2. Known history of peripheral arterial disease.

TREATMENT PLAN

1. I have drawn the area of erythema to be sure there would be no proximal progression and I have advised them to monitor this.
2. We will add Cipro in the event that that may be helpful, low dose 250 mg is present regimen.
3. Wound site today dressed again with Bactroban ointment and knuckle band-aide. A prescription for Bactroban provided for his daily use.
4. We will see him back again in a week to 10 days, sooner if his needs arise.

Electronically signed by
1/14/2019 11:18:56 AM

DD: 1/14/2019 9:16:43 AM DT: 1/14/2019 9:36 AM

PATIENT NAME: [redacted]
DATE OF BIRTH:
PROVIDER:
DATE OF VISIT: 01/22/2019
CLINIC ID NUMBER: 1020160

REASON FOR VISIT
Wound management.

HISTORY OF PRESENT ILLNESS
The patient is here today for the above. He has been using the antibiotic cream and the insert, but has failed to have complete resolution of the wound. He has no discomfort, but it is neuropathic.

PFSH/REVIEW OF SYSTEMS
Read, reviewed, without interval change from the 01/14/2019 visit. He has tolerated the antibiotics well.

PHYSICAL EXAMINATION
Constitutional: Well-developed male. Alert, oriented, communicative, pleasant. He is in his sandal and the _____ [TIME: 00:34] insert. His gait pattern is slight shuffled, but stable and at baseline.

Right Foot Exam: Continued hammertoe deformity, nonreducible. Slight erythema persists at the site. The wound is superficial. There is good bleeding bed after debridement. There are no acute findings of infection, but resolution of the localized cellulitis is not complete. Neurovascular status remains stable.

CLINICAL IMPRESSION

1. Second digit diabetic foot ulcer, right foot, Wagner 2.
2. Rigid hammertoe deformity complicating the above.

TREATMENT PLAN

1. See wound note for debridement.
2. Will continue back on empiric doxycycline as the hospital cultures were not helpful.
3. DNA cultures taken today.
4. I have spoken with him about correction of the toe as the only way of being able to get this ultimately to heal. In the meantime, I would like to get more of the erythema resolved. I have therefore, continued the antibiotics.
5. He has a buttress pad at home and I have recommended he use that on the 3rd toe.
6. I will see him back next week.

Electronically signed by
1/22/2019 8:49:47 PM

DD: 1/22/2019 8:42:08 AM DT: 1/22/2019 11:45 AM

PATIENT NAME: [redacted]
DATE OF BIRTH:
PROVIDER:
DATE OF VISIT: 02/04/2019
CLINIC ID NUMBER: 1020160

REASON FOR VISIT
Go over results.

HISTORY OF PRESENT ILLNESS
The patient is here today to go over results of the MRI of the right foot. Although the infectious disease consult has been made, he has not been contacted by [redacted] in the meantime, he is tolerating the antibiotics well. Awakes up in the morning and the toe looks pretty normal, but once he has walked around on it, it does get somewhat more red. He denies fevers, chills, nausea, vomiting, systemic evidence of infection.

PFSH/REVIEW OF SYSTEMS
Read, reviewed, without interval change from the 01/29/2019 visit.
PHYSICAL EXAMINATION
Constitutional: Well-developed male. Alert, oriented, communicative, pleasant.

Right Foot Exam: Essential stable findings. Diminished pulses consistent with his PAD. The ulceration has remained fairly stable. Good beefy granulation tissue. It appears to have dry callusing around the wound edges. It measures about the same as 1 x 0.8 cm. From the plantar aspect of the site, it does not appear impressive, infected. Distal phalanx aspect still edematous. Photograph of the site today taken.

DIAGNOSTIC READINGS & INTERPRETATION
MRI images and reports indicated marked bone marrow edema, limited to distal phalanx 2nd toe of the right foot consistent with osteomyelitis and the ulceration tip of the toe. Changes in the foot consistent with neuropathy.

CLINICAL IMPRESSION

1. Osteomyelitis, limited to the distal phalanx 2nd digit, right foot.
2. History of diabetes mellitus, peripheral arterial disease and neuropathy complicating the above.
3. Hospice status requesting conservative care.

TREATMENT PLAN

1. Although I would expect minimal reduction in deformity, at this point any reduction may be helpful and I have therefore recommended a percutaneous flexor tenotomy/capsulotomy which we can schedule at his convenience.
2. We have contacted Dr. Manikal's personally office to expedite his referral and for coordination of care.
3. I will see him back next week and we can schedule for the procedure at that point.

Electronically signed i
2/10/2019 8:34:10 AM

DD: 2/4/2019 8:43:11 AM DT: 2/4/2019 9:23 AM

PATIENT NAME: [redacted]
DATE OF BIRTH:
PROVIDER:

PREOPERATIVE DIAGNOSES

1. Known osteomyelitis, distal 2nd digit, right foot.
2. Nonhealing ulceration/diabetic foot ulcer, 2nd toe, right foot.
3. Partially reducible contracture, 2nd toe, right foot.

POSTOPERATIVE DIAGNOSES

1. Known osteomyelitis, distal 2nd digit, right foot.
2. Nonhealing ulceration/diabetic foot ulcer, 2nd toe, right foot.
3. Partially reducible contracture, 2nd toe, right foot.

PROCEDURE PERFORMED
Percutaneous flexor tenotomy and capsulotomy, 2nd digit, right foot.

SURGEON

ANESTHESIA
Local.

RATIONAL FOR PROCEDURE
This is an 82-year-old male. He is in Hospice and has been directed to have only conservative therapy for the ongoing noted osteomyelitis, 2nd toe of the right foot. He is doing well on antibiotics but has failed to resolve. He has been in a diabetic shoe, surgical shoe and offloading as well as pad, which is not giving good resolution. I have offered him a percutaneous flexor tenotomy to reduce at least some of the plantar grade pressure with which he wishes to proceed. Informed consent, risks, benefits and alternatives were thoroughly discussed and written in verbal form. No guarantees given nor were they implied. Most specifically, I advised him that going forward, at least reduction of the distal involved aspect of bone would be of benefit. He acknowledges understanding and consented to the above.

PROCEDURE DETAIL
While in the treatment chair, preprocedural pause was taken. Local infiltration was then provided at the plantar aspect of the 2nd digit, right foot with a total of approximately 3 mL of 1% Xylocaine plain mixed with 1:1 ratio with 0.25% Marcaine plain. The right foot was then prepped and draped in the usual manner for surgery. Attention was then directed to the plantar aspect of the 2nd ray where via a #61 blade and a percutaneous flexor longus and brevis tendon, was reaped as well as the capsule of the proximal interphalangeal joint. The digit showed reduction in about 50% of the contracture. The incisions were then irrigated and closed with Steri-Strips and the digit was maintained in a more corrected position. The surgical site was dressed with gauze and compression dressing. He is rescheduled for followup in 24-48 hours. He will remain in the surgical shoe. He tolerated this quite well.

Electronically signed by:
2/18/2019 12:45:36 PM

DD: 2/17/2019 9:47:30 PM DT: 2/18/2019 11:50 AM

PATIENT NAME: [redacted]
DATE OF BIRTH:
PROVIDER:
DATE OF VISIT: 02/15/2019
CLINIC ID NUMBER: 1020160

REASON FOR VISIT
Postop.

HISTORY OF PRESENT ILLNESS
The patient is status post percutaneous tenotomy 2nd toe of the right foot. He is doing well. He is having no pain but is neuropathic.

PHYSICAL EXAMINATION
Right Foot Exam: There is actually less erythema and a straightened appearance to the digit. Wound site is dry. Steri-Strips maintained in place.

CLINICAL IMPRESSION
Excellent status post percutaneous tenotomy.

TREATMENT PLAN

1. Today, we will leave the Steri-Strips in place, as they are holding the digit in good positioning. A Band-Aid applied.
2. We will see him back again next week.

[redacted]
Electronically signed by
2/18/2019 10:10:25 AM

DD: 2/15/2019 12:39:11 PM DT: 2/18/2019 9:10 AM

PATIENT NAME: [redacted]
DATE OF BIRTH:
PROVIDER:
DATE OF VISIT: 7/10/2019
CLINIC ID NUMBER: 1020160

REASON FOR VISIT
Wound surveillance.

HISTORY OF PRESENT ILLNESS
The patient is here for a wound check, second toe, right foot, completely resolved.

PFSH/REVIEW OF SYSTEMS
Read, reviewed, and without interval change from previous visit.

PHYSICAL EXAMINATION
Constitutional: Well-developed male, alert and oriented, communicative, pleasant. Ambulation pattern is unchanged from previous visit.

CLINICAL IMPRESSION
Healed 2nd toe wound/OM.

TREATMENT PLAN
We will discharge him at this time.

[redacted]

DD: 07/10/2019 10:18:41 AM DT: 07/10/2019 11:41:00 PM

PATIENT ID: 1020160
PATIENT:
DATE OF BIRTH

EXAM DATE: 01/30/2019
ACCESSION #: A86E
REFERRED BY:

MRI FOOT - RIGHT WO W CONTRAST

HISTORY: Osteomyelitis of the 2nd toe.

COMPARISON STUDIES: Right foot series dated 01/29/2019.

TECHNIQUE: Multiplanar sequences with T1, intermediate, T2, and/or T2*-weighted image contrast.

FINDINGS:

Osseous: Marked bone marrow edema and enhancement are seen in the distal phalanx of the 2nd toe with adjacent skin ulceration indicating osteomyelitis. The middle phalanx of the 2nd toe has a normal bone marrow signal with no evidence of infection. The remaining phalanges have a normal bone marrow signal. The bones of the foot are aligned. Mild degenerative changes noted at the 1st metatarsophalangeal joint with joint space narrowing and small osteophyte formation.

Tendons/muscle: The flexor tendons and extensor tendons are intact. Mild edema and fatty atrophy are identified throughout the visualized muscles of the foot consistent with neuropathic changes.

General: Irregularity at the skin surface at the tip of the 2nd toe indicates skin ulceration with moderate edema throughout the 2nd toe subcutaneous soft tissues. No fluid collection or evidence of a drainable abscess. Mild edema extends throughout the subcutaneous soft tissues of the dorsal foot.

IMPRESSION:

1. Marked bone marrow edema and enhancement limited to the distal phalanx of the 2nd toe indicating osteomyelitis.
2. Skin ulceration at the tip of the 2nd toe with moderate adjacent soft tissue edema and mild edema extending into the dorsal foot.
3. Mild degenerative change at the 1st metatarsophalangeal joint.
4. Mild edema and fatty atrophy throughout the visualized muscles of the foot consistent with neuropathic changes.

Electronically signed by [redacted] 30, 2019 3:45:35 PM)

SUBSPECIALTY INTERPRETATION PROVIDED BY

RADSOURCE

[redacted]

Patient:		Specimen:	RT 2ND TOE	Physician:	
DOB:	02/19/1936	Received:	01/23/2019 10:55 AM	Phone:	
Patient ID:	0219193632033	Completed:	1/25/2019	Fax:	
Gender:	Male	Accession:	244463	Collected:	01/22/2019 10:55 AM

Next Generation Sequencing Results

MicroGen Diagnostics' comprehensive testing (patent pending) is a relative quantitative universal test for bacteria/fungi. DNA sequencing methods are used to identify the microorganisms' genetic signatures and the estimated percentage of organisms present in the specimen. Virtually all bacteria/fungi are screened for and the most predominant populations are reported.

Rapid Screening Swab Results	Amount (N/A)
Bacterial Load	Low
Enterococcus faecalis	Not Detected
Klebsiella pneumoniae	Not Detected
Enterococcus faecium	Not Detected
Streptococcus pyogenes	Not Detected
Streptococcus agalactiae	Not Detected
Candida albicans	Not Detected
Pseudomonas aeruginosa	Not Detected
Staphylococcus aureus	Not Detected
Resistance Genes Detected	
None	
Resistance Genes Not Detected	
Vancomycin	
Methicillin	
Beta-lactam	
Carbapenem	
Macrolide	
Aminoglycoside	
Tetracycline	
Quinolone	

Comprehensive Identification (Sequencing Results)	
Detected Bacteria:	
Finegoldia magna	26%
Staphylococcus epidermidis	17%
Corynebacterium tuberculostearicum	17%
Corynebacterium pseudogenitalium	13%
Pseudomonas putida	5%
Achromobacter xylosoxidans	4%
Anaerococcus vaginalis	2%
NO FUNGAL SPECIES DETECTED	

Only relative Rapid Screening Quantitation is obtainable from swab samples.

Complete Antibiotic Analysis [Next Page(s)]

ANTIBIOTIC DISCLAIMER. Southwest Regional PCR assumes no liability to patients with respect to the actions of physicians, health care facilities and other users, and is not responsible for any injury, death or damage resulting from the use, misuse or interpretation of information obtained through this antibiotic report. Therapeutic options listed by the program are based upon national antibiotic susceptibility data and antibiograms. Therapy should not be undertaken without a thorough assessment of the indications, contraindications and side effects of any prospective drug or intervention. Furthermore, the database is curated and derived from incidence and prevalence statistics whose accuracy will vary widely for individual diseases and regions of the country. Changes in endemicity, incidence, and drugs of choice may occur. The list of drugs, infectious diseases and even country names will vary with time. Although we endeavor to include such new information on a timely basis, a delay cannot be avoided. For more information please contact us at 855-208-0019

DISCLAIMER: (i) This test was developed and performance characteristics have been determined by Southwest Regional PCR Laboratory. It has not been cleared or approved by the U.S. Food and Drug Administration (FDA), however, the FDA has determined that such clearance or approval is not necessary. This test is used for clinical purposes. Its use should not be regarded as investigational or for research. This laboratory is certified under the Clinical Laboratory Improvement Amendments of 1988 (CLIA 88) as qualified to perform high complexity clinical laboratory testing. (ii) A negative result does not rule out the presence of PCR inhibitors, or DNA extraction inhibitors such as lidocaine. In patients specimens or microbial DNA concentrations below the level of detection of the assay. (iii) This test is performed pursuant to an agreement with Roche Molecular Systems, Inc. (iv) Relative quantitation of swabs refers to analyte load levels of <10^5, 10^5 to 10^7, and >10^7 for low, medium and high respectively

Laboratory Director:

0219193632033-244463.

Class	Generic	Topical	PO	IV		26	2	17	17	13	5	4
					Gram	+	+	+	+	+	-	-
					Resp	An	An	FAn	FAn	FAn	Ae	Ae
Glycopeptide	vancomycin	√		√		√		√	√	√		
	tmp/smx (Bactrim)	√	√	√		-		√				
lincosamide	clindamycin (Cleocin)	√	√	√		√	√					
Nitroimiadazole Antibiotic	metronidazole	√	√	√		√	√					
Oxazolidine	linezolid	√	√	√		√	√	√	√	√		
anti-psuedomonal penicillins	piperacillin/tazobactam	√		√			√	√			√	√
Carbapenem	doripenem			√				√			√	√
Cephalosporin 1st generation	cephalexin (Keflex)		√					√				
Extended spectrum penicillin/beta-lactamase inhibitor	amoxicillin/clavulanate (Augmentin)		√					√				
fluoroquinolone	ciprofloxacin (Cipro)	√	√	√				√		√	√	√
	levofloxacin		√	√				√				
RNA sythetase inhibitor	Mupirocin (bactroban)	√						√				
Macrolide	erythromycin	√	√	√					√			
penicillins	penicillin g			√					√			
Tetracycline	doxycycline	√	√	√					√			
amino penicillins	ampicillin		√	√						√		√
Aminoglycoside	gentamicin	√		√						√		
	amikacin	√		√							√	√
Polymyxin antibiotic	colistimethate (colistin)	√		√							√	√

Gram Stain
+: Positive, -: Negative, I:Indeterminate, N: not applicable U: Unknown
Respiration
Ae: Aerobic, An: Anaerobic, FAn: Facultative anaerobic, Unk: Unknown
* Resistance genes found. Consultation with a pharmacist on an appropriate course of treatment with recommendations made at the discretion of the physician based on known interaction and concentrations is recommended.

Cipro & last week
+ tmp/smx

Lab Supplied Demographics:

DOB/Age 02/19/1936 82y **Sex** M

[redacted]

SRS Supplied Demographics:

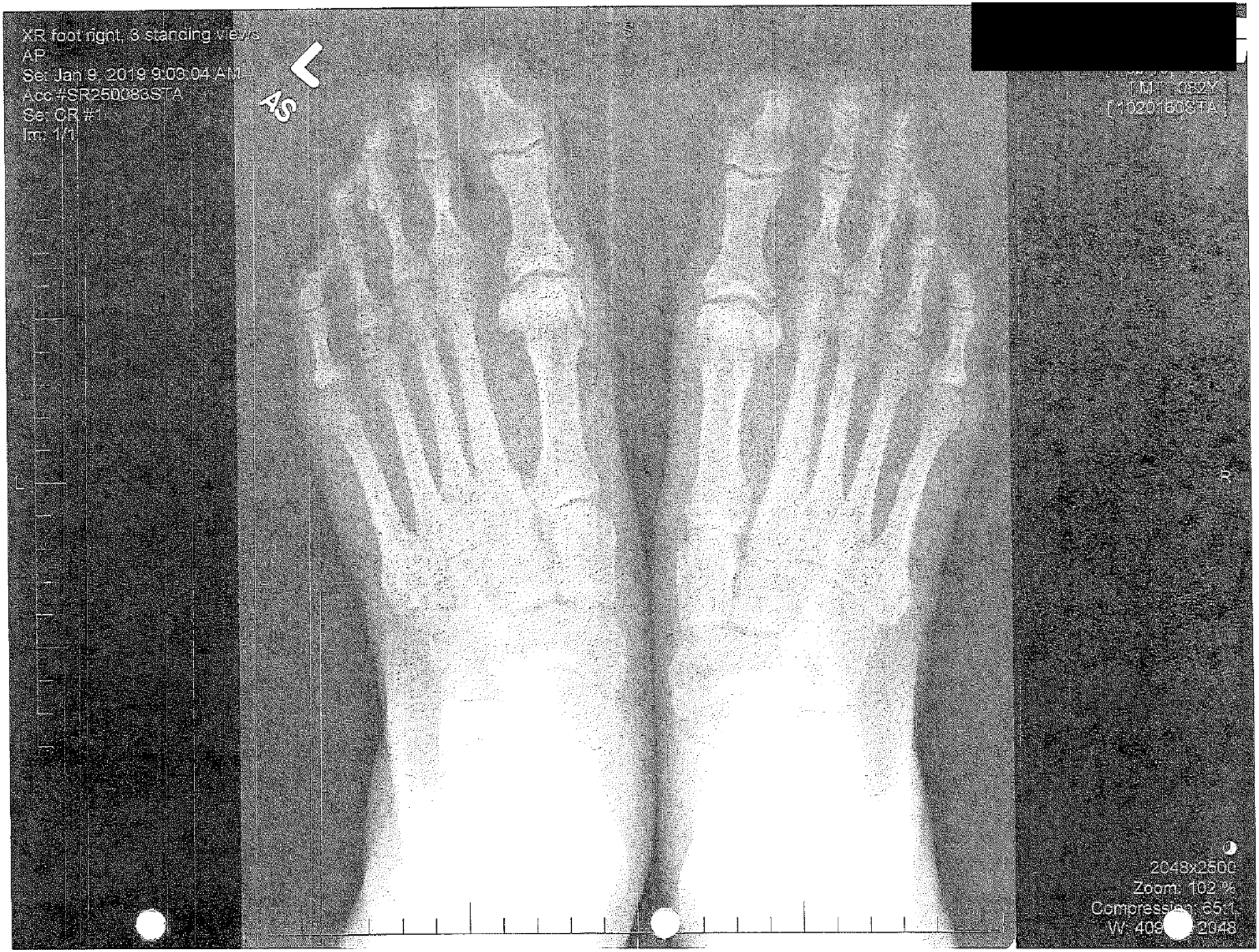
1023054540
DOB/Age 02/19/1936 82y **Sex** M

Provider _ __ .

Report Status F

Ordered	01/11/2019
Collected	01/09/2019
Received	01/09/2019
Reported	01/11/2019
Requisition	1900901718

Test Name	Result	Flag	Units	Ref Range	Status
Routine Culture (Auto Generated)					
Routine Culture MRN: 1371674 Source - Swab - N Site - Toe, 2, Right - N Gram Stain - Few White Blood Cells;Few Gram positive cocci in clusters;Few Gram positive cocci in pairs - N Preliminary Result - 3+ Normal Skin Flora To Date; Further incubation required - N Micro Culture Result - 3+ Normal Skin Flora - N Performing Lab: FLHL					F


XR foot right, 3 standing views
AP
Se: Jan 9, 2019 9:08:04 AM
Acc #SR250083STA
Se: CR #1
Im: 1/1
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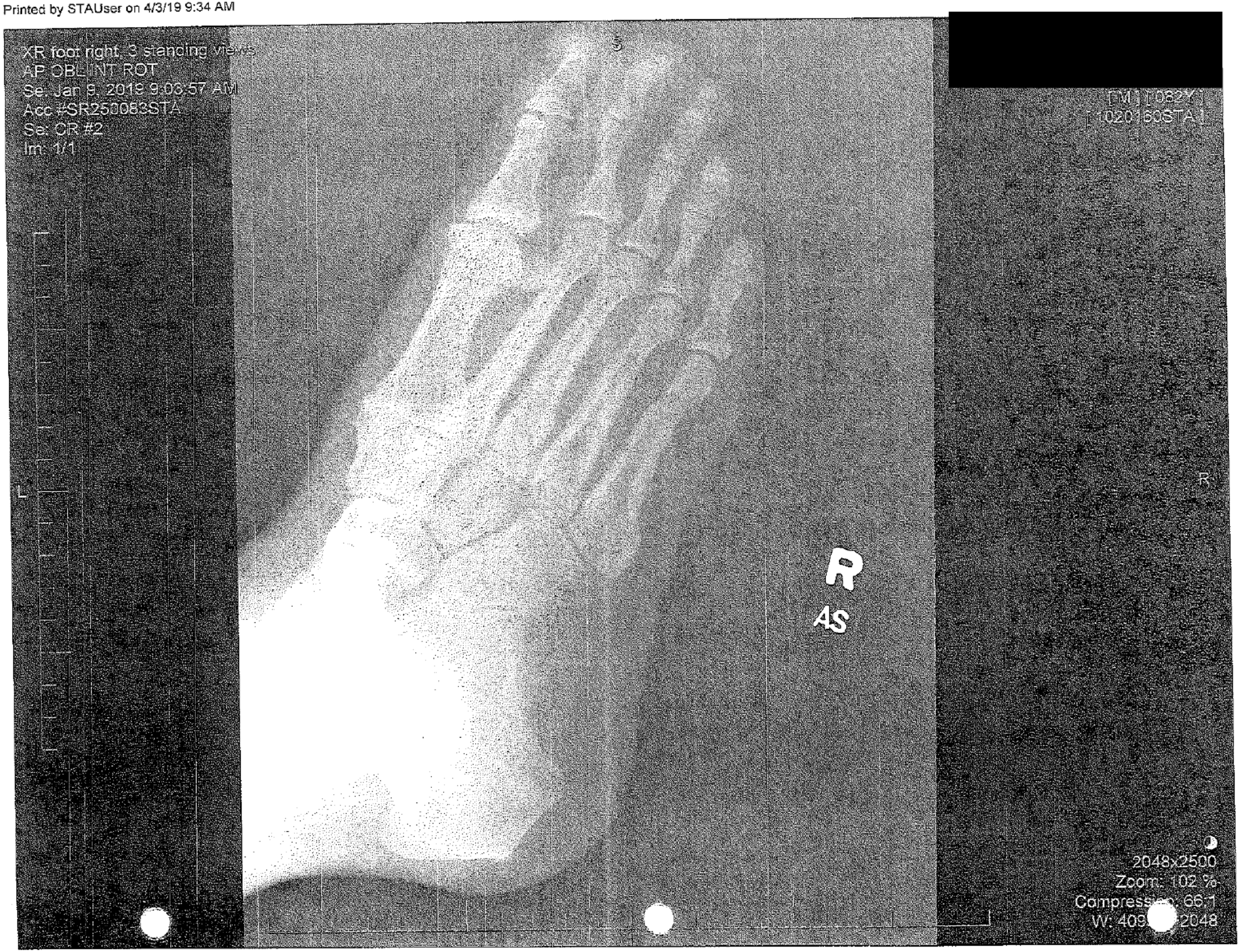
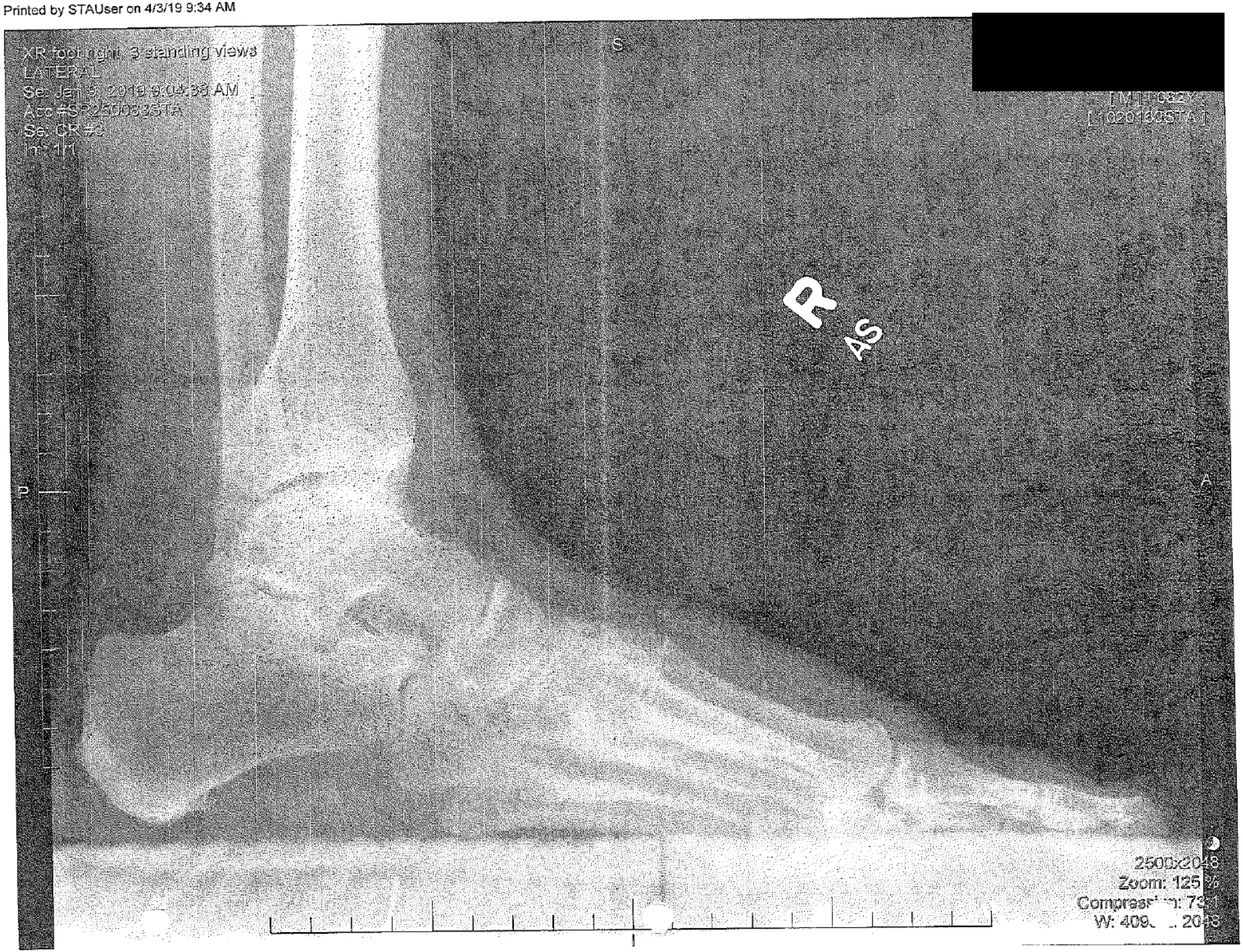
2048x2500
Zoom: 102 %
Compression: 65:1
W: 409 2048




XR tooth right 3 standing views
LATERAL
Se: Jan 5, 2019 9:04:38 AM
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Se: CR #3
Im: 1/1
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[1020160STA]
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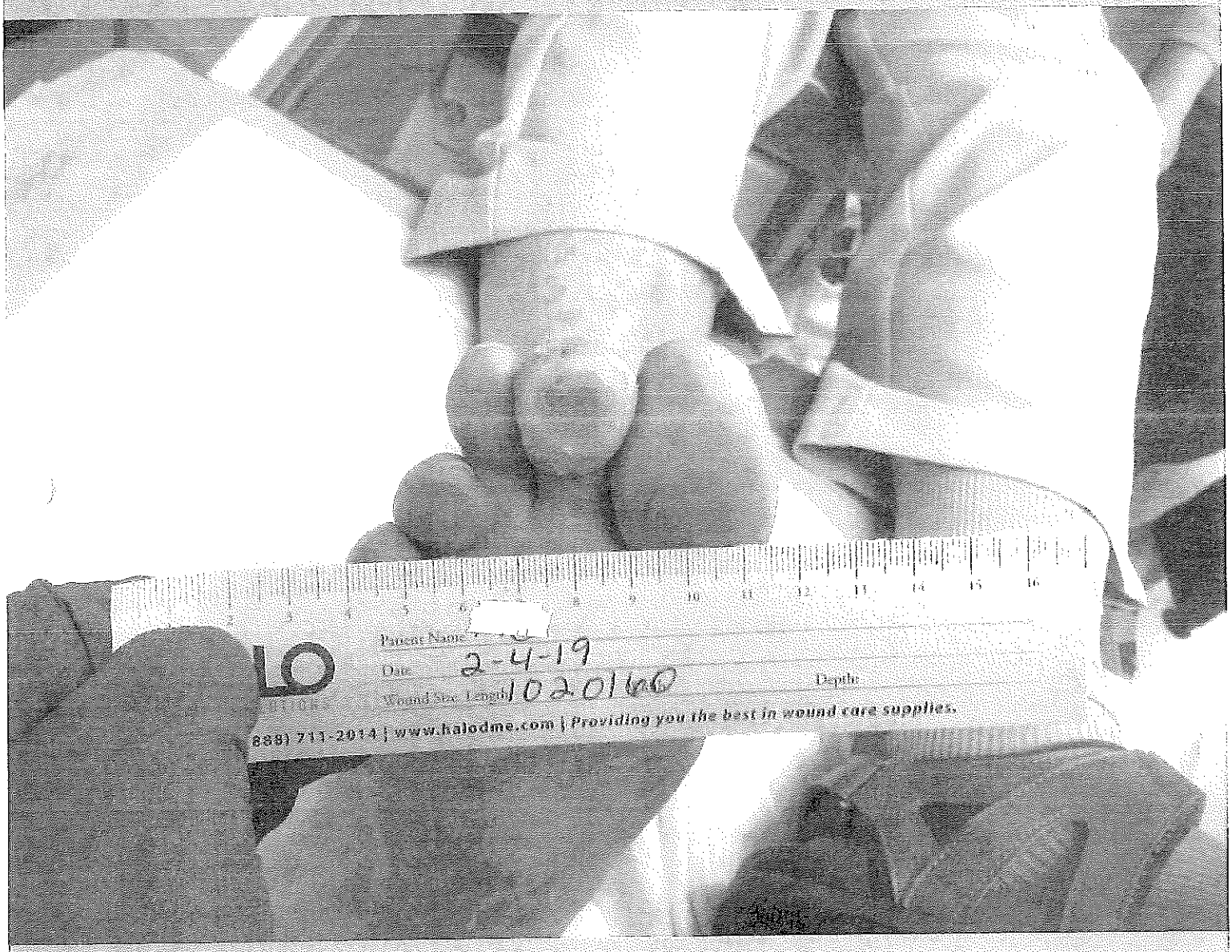
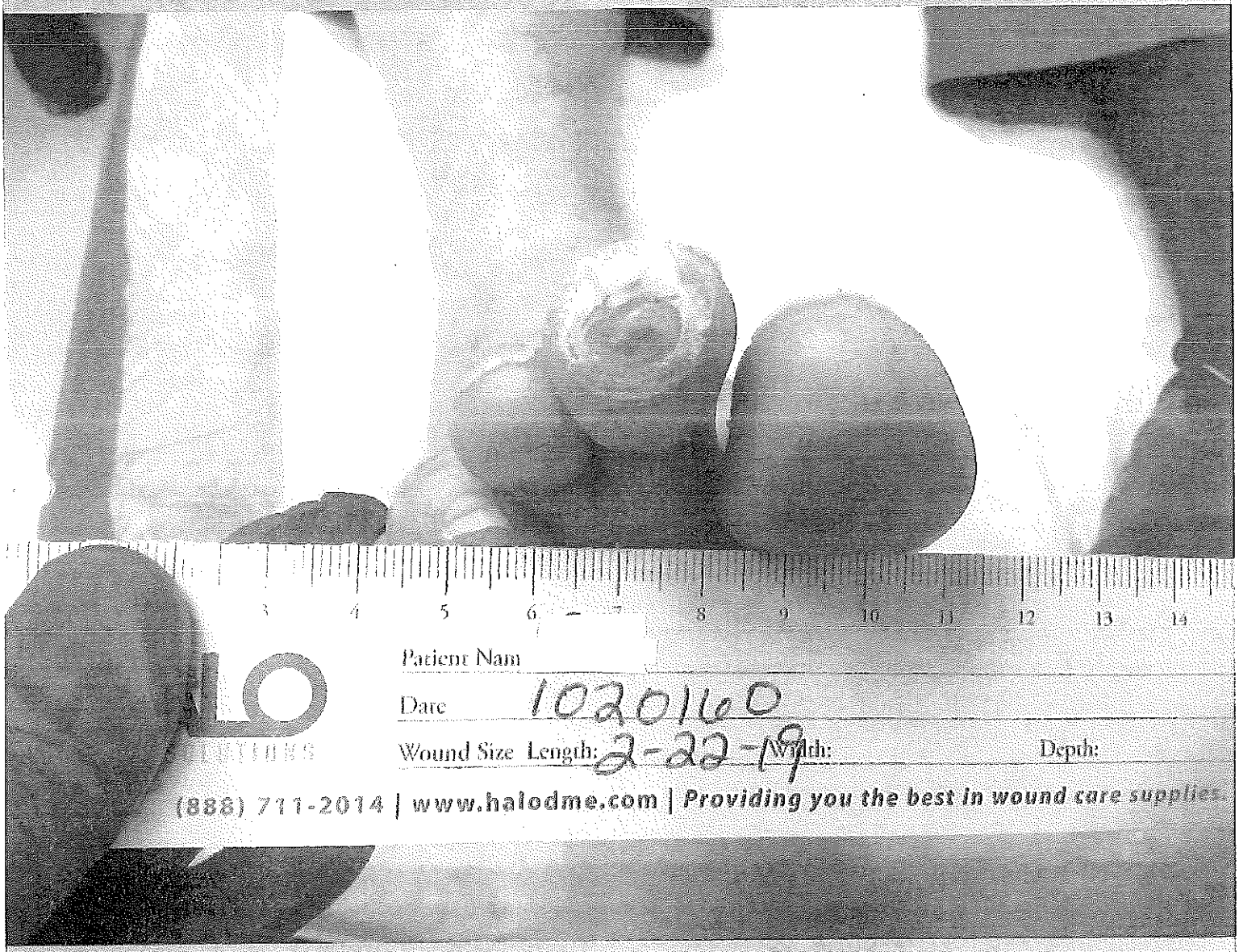
Zoom: 125%
W: 409 2048


Patient Name:
Date: 2-4-19
Wound Size: Length 10 Width 20 Depth 10
(209) 211-2019 | www.halodme.com | Providing you the best in wound care supplies.


Patient Name
Date 2-4-19
Wound Size Length 10 20 60
Depth
(888) 711-2014 | www.halodme.com | Providing you the best in wound care supplies.

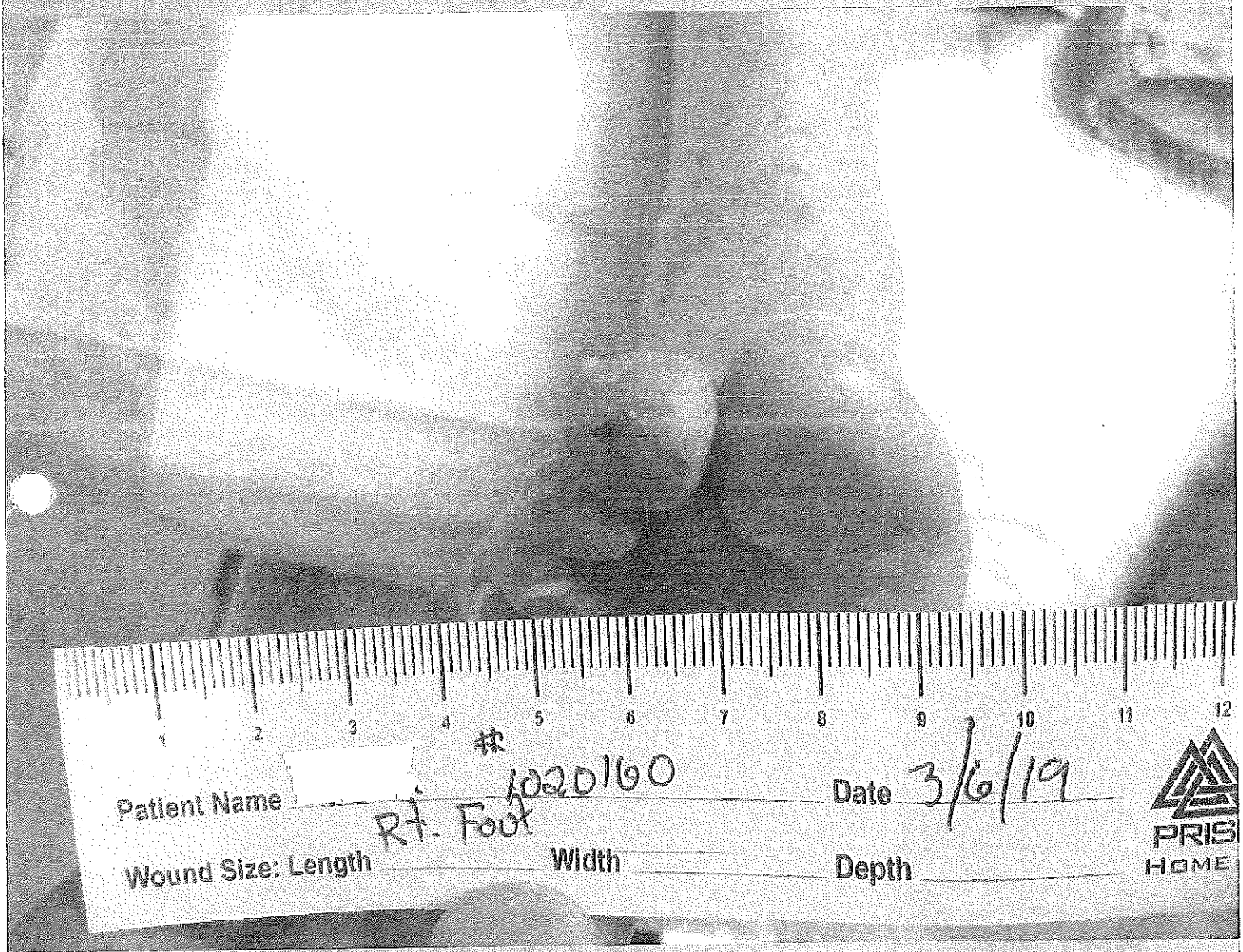


Patient Nam

Date 10201eO

Wound Size Length: 2-22-19 Width: Depth:

(888) 711-2014 | www.halodme.com | *Providing you the best in wound care supplies*


1 2 3 4 5 6 7 8 9 10 11 12
Patient Name
#
4020100
Rt. Foot
Date 3/6/19
Wound Size: Length
Width
Depth
PRIS
HOME

OSSEOUS PROCEDURE CASE EXAMPLE

PATIENT NAME: [redacted]
DATE OF BIRTH:
PROVIDER:
DATE OF VISIT: 9/7/2019
CLINIC ID NUMBER: 22278

CASE HISTORY REPORT COVER PAGE FOR

Case Report Number: 22278

Category: Bone correction.

Condition Treated: Tailor's bunion deformities bilaterally.

Patient Age: 62

Initial Date of Treatment: 06/01/2016

Date of Surgery: 12/11/2018 and 10/30/2018

Chief Complaint: (History/duration/prior treatment): Symptomatic tailor's bunion deformities. The patient was initially seen 06/01/2016 with pain about the fifth metatarsophalangeal joints of her bilateral feet. She was treated conservatively for years but failed to get resolution. Conservative therapy for years with shoe gear changes and mechanical support as well as anti-inflammatory therapy. She failed to get resolution and therefore requested surgical intervention which was provided on the above dates.

Medications: Spiriva, Zithromax, tramadol, thyroid, pravastatin, and cyclobenzaprine.

Exam Findings: Tailor's bunion deformity with varus rotation of the bilateral feet. Pain associated with palpation of the lateral eminence. Tenderness at the site but no ulcerations observed. Good pedal pulses and tissue perfusion. Her sensation was intact. No acute findings evident.

Assessment/Diagnosis: Bilateral tailor's bunion deformities.

Outcome/Complications: After successful correction of the right foot, the patient ultimately went on to have correction of the left foot and was discharged from my care for both on 03/05/2019 and is able to wear all shoes without difficulty.

DD: 09/07/2019 11:52:14 AM DT: 09/08/2019 11:50:00 PM

PATIENT NAME: [redacted]
DATE OF BIRTH:
PROVIDER:
DATE OF VISIT: 10/08/2018
CLINIC ID NUMBER: 22278

REASON FOR VISIT
Bilateral foot pain.

HISTORY OF PRESENT ILLNESS
The patient is well know to me. She is a 62-year-old female seen last in 2016 with a complaint of a tailor's bunion and tried using changes in shoe gear, which gave her some, but not complete resolution. The pain has actually gotten worse and is interfering with walking and daily activities. In spite now of being retired, she states it is a sharp, stabbing, sometimes burning type pain and she wishes to discuss correction, which we had alluded to at the last visit. She points to the base of the 5th toes bilaterally as the source of discomfort, the left foot worse than the right. She had some residual weakness on the right extremity, which was about 90% ameliorated with physical therapy. She is aware of still some residual weakness, however.

PFSH/REVIEW OF SYSTEMS
Read, reviewed, and signed today by me. Of note, she had a recent mini TIA for which she is now on aspirin therapy, but all testing by her primary care physician, cardiologist was normal.

PHYSICAL EXAMINATION
Constitutional: A well-developed female, alert, oriented, communicative, pleasant, ambulates with a nonantalgic gait pattern. She is in a ballet style of flat, accompanied by her husband. Gait pattern is stable.

Bilateral Lower Extremity Exam: Good pedal pulses and tissue perfusion although capillary return is a bit sluggish, yet still less than 4 seconds. Digits are cool, but pink. Distal hair growth is observed bilaterally. There is a bit of irritation over the bony prominence dorsomedial aspect of the moderate tailor's bunion deformity, which is noted bilaterally and varus rotation of the 5th toes. Palpation of the area does recreate her discomfort and is localized to this side. No acute findings otherwise noted. No fracture or dislocation evident.

DIAGNOSTIC READINGS AND INTERPRETATION
X-rays taken today, 3 view standing of the bilateral feet, AP, lateral, and oblique reveal tailor's bunion deformity with varus rotation of 5th digit. The IM angle is slightly increased on the left as compared to the right. No other bony abnormalities identified in the bilateral views. High foot architecture is noted.

CLINICAL IMPRESSION
1. Cavus foot type.
2. Tailor's bunion deformity.

TREATMENT PLAN
Treatment today, I have discussed with her both traditional osteotomies with screw fixation as well as minimally invasive options. At this point, she would like to proceed with surgical correction understanding both and would prefer the less invasive option understanding as well that it is non-fixated. We can schedule this at her convenience and we will see her back for more specific informed consent at that time.

Electronically signed by
10/9/2018 10:16:27 AM

DD: 10/8/2018 3:47:57 PM DT: 10/9/2018 12:14 AM

PATIENT NAME: [redacted]
DATE OF BIRTH:
PROVIDER:
DATE OF SURGERY: 12/11/2018

SURGERY CENTER ID#
1758

PREOPERATIVE DIAGNOSIS
Painful tailor's bunion deformity, right foot.

POSTOPERATIVE DIAGNOSIS
Painful tailor's bunion deformity, right foot.

PROCEDURE PERFORMED

1. Tailor's bunion correction via 5th metatarsal osteotomy and partial ostectomy all of the right foot.
2. Fluoroscopic guidance throughout the above.

SURGEON
DPM

ANESTHESIA
Local infiltration of approximately 20 mL of 0.5% Marcaine plain mixed in 1:1 ratio with 1% Xylocaine plain. Nurse monitored sedation utilizing 2 mg of Versed, 50 mcg Fentanyl with 400 mL fluid.

HEMOSTASIS
Not applicable.

RATIONALE FOR PROCEDURE
This is a 62-year-old female who has failed conservative intervention for a symptomatic tailor's bunion deformity to the bilateral feet. The left foot, she has done extremely well with a similar procedure which was performed about 2 months ago. She was advised specifically that a good outcome on one extremity does not necessarily equate to the same, that the same risks, benefits, and alternatives remain available. She acknowledged her willingness to proceed.

PROCEDURE DETAIL
While in the preoperative holding area, I personally initialed the site. The patient was then brought into the operating room and a timeout was taken to reconfirm patient, part and procedure. Sedation was then provided via the above mixture. With the above-mentioned Marcaine and Xylocaine mixture local infiltration anesthesia was provided about the 5th metatarsophalangeal joint.

The right lower extremity was then prepped and draped in the usual manner for surgery. Attention was then directed to the lateral plantar aspect just proximal to the 5th metatarsal head where a 0.3 cm incision was placed with a 64 blade and deepened to bone. Periosteal elevator was used and a hand rasp was inserted followed by the use of a short Isham bur to remodel and reduce the bony exostosis. Bone paste was extruded from this site which was then copiously irrigated. This incision was closed with a simple suture of 4-0 nylon. Attention was then directed to the dorsomedial aspect of the metatarsal about the level of the surgical neck where a similar incision was placed and deepened to bone. At this site with the use of a long Isham bur and rotating osteotome after periosteal elevator allowed for access directly to bone, an osteotomy was performed from dorsal distal to plantar proximal and the metatarsal head shifted medially. This was checked on fluoroscopy noting no complications and good alignment of the preprocedural angulation. The site was then copiously irrigated and closed with 1 simple suture of 4-0 nylon. The surgical site about the metatarsal head was then instilled with 0.5 mL of dexamethasone. A compression bandage was applied with Betadine-soaked Adaptic, gauze, Kling and

02/28/1956

mild Coban compression.

The patient tolerated the procedure extremely well and left the operating room with no untoward surgical signs and all vital signs stable. She is rescheduled for a followup tomorrow.

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12/15/2018 9:48:50 AM

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[redacted]

PATIENT NAME: [redacted]
DATE OF BIRTH: [redacted]
PROVIDER: [redacted]
DATE OF VISIT: 01/21/2019
CLINIC ID NUMBER: 22278

REASON FOR VISIT
Postop.

DATE OF SURGERY

1. Right foot, 12/11/2018.
2. Left foot, 10/30/2018.

HISTORY OF PRESENT ILLNESS
The patient is here today for the above. She is very pleased. She has had little to no pain and is back in regular shoes.

PHYSICAL EXAMINATION
Constitutional: Well-developed female. Alert, oriented, communicative, pleasant. Ambulation pattern non-antalgic.

Bilateral Lower Extremity Exam: Stable neurovascular status. Wound sites well healed bilaterally and there is excellent correction of the deformity.

DIAGNOSTIC READINGS & INTERPRETATION
X-rays taken today, 3 views standing of the left foot, AP, lateral and oblique reveal progressive resolution of healing and good lateral positioning of the 5th metatarsal head.

CLINICAL IMPRESSION
Status post tailor's bunion correction bilaterally.

TREATMENT PLAN

1. She gear and activity to tolerance. Photographs of both feet taken.
2. We will see her back again in 6 weeks.

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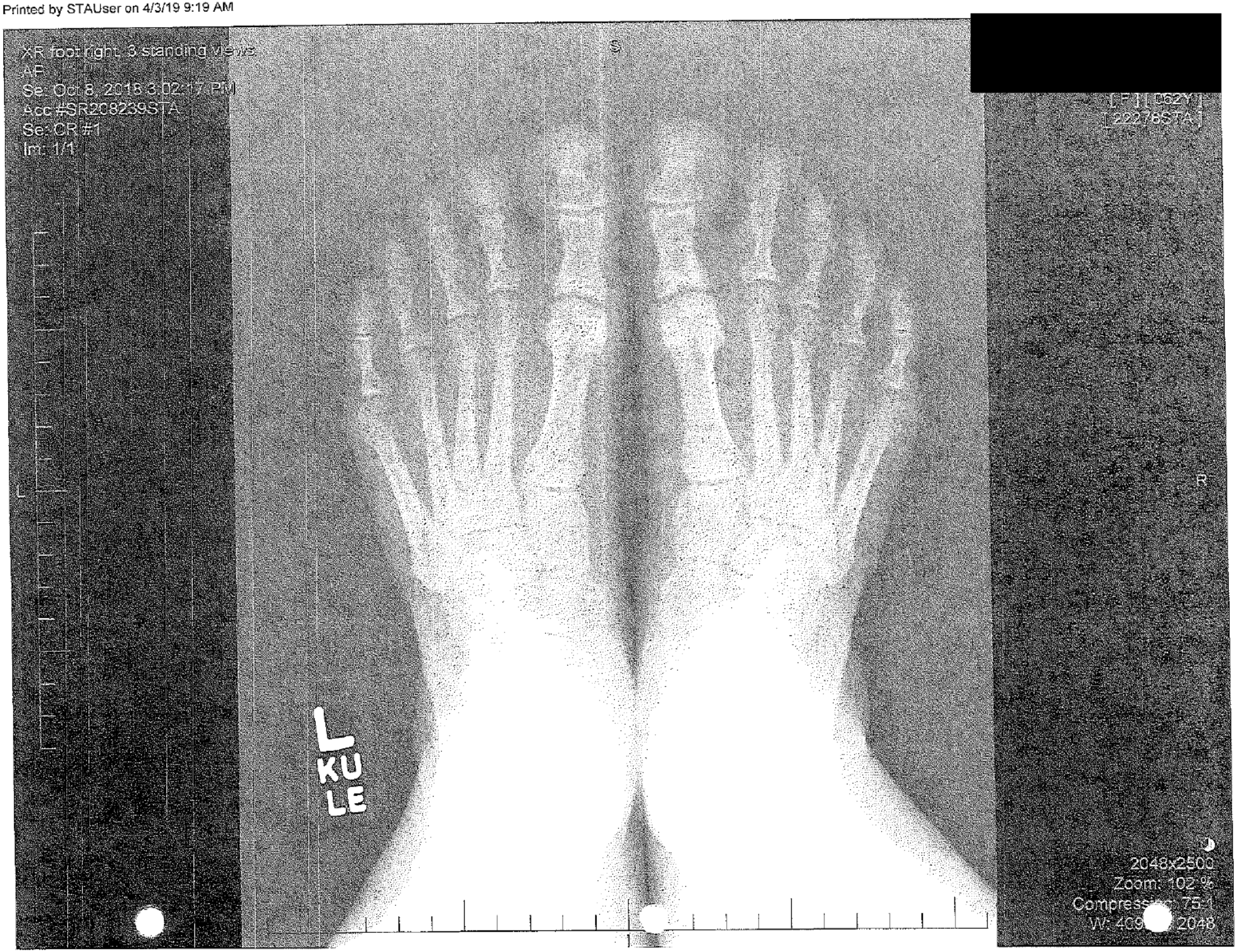
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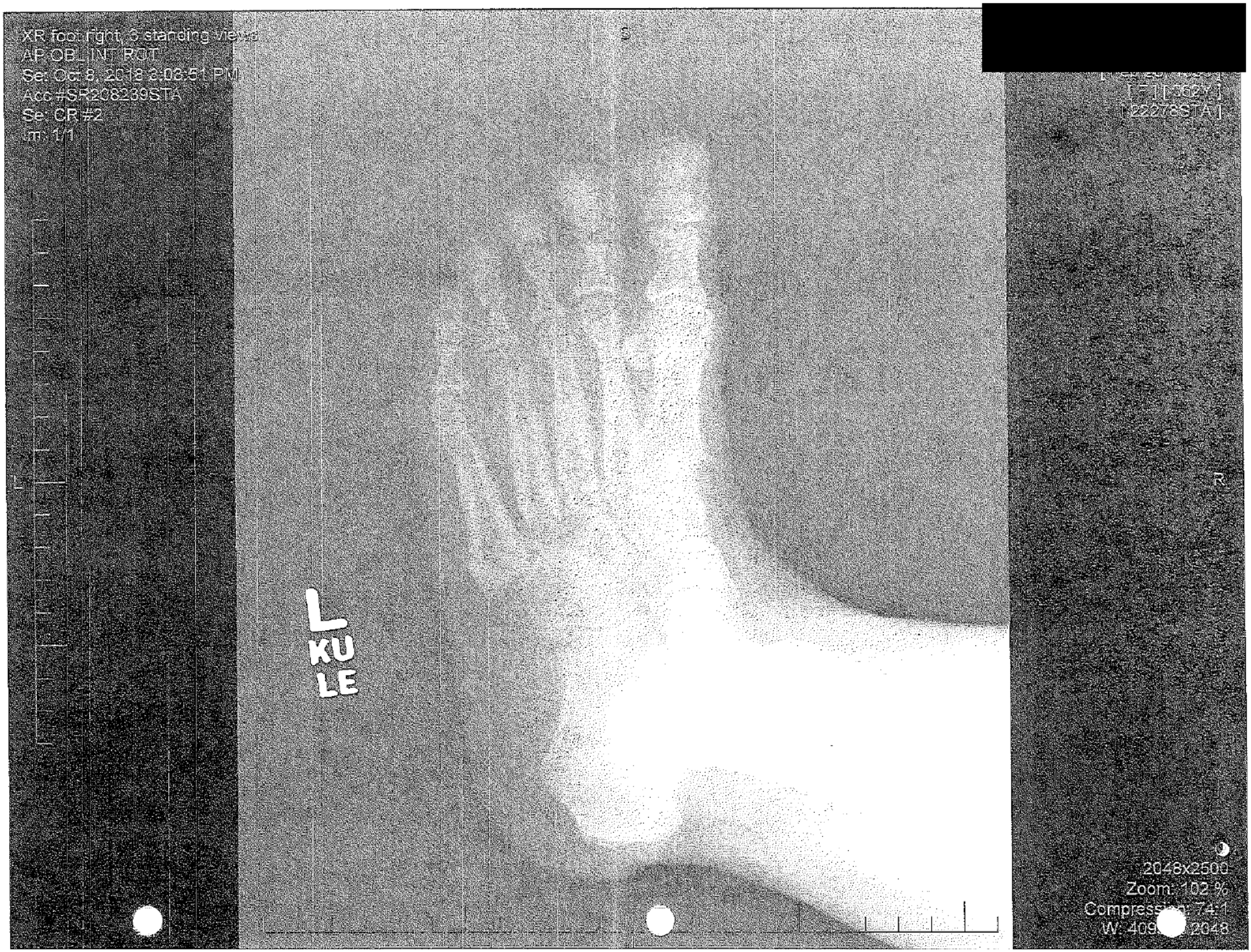
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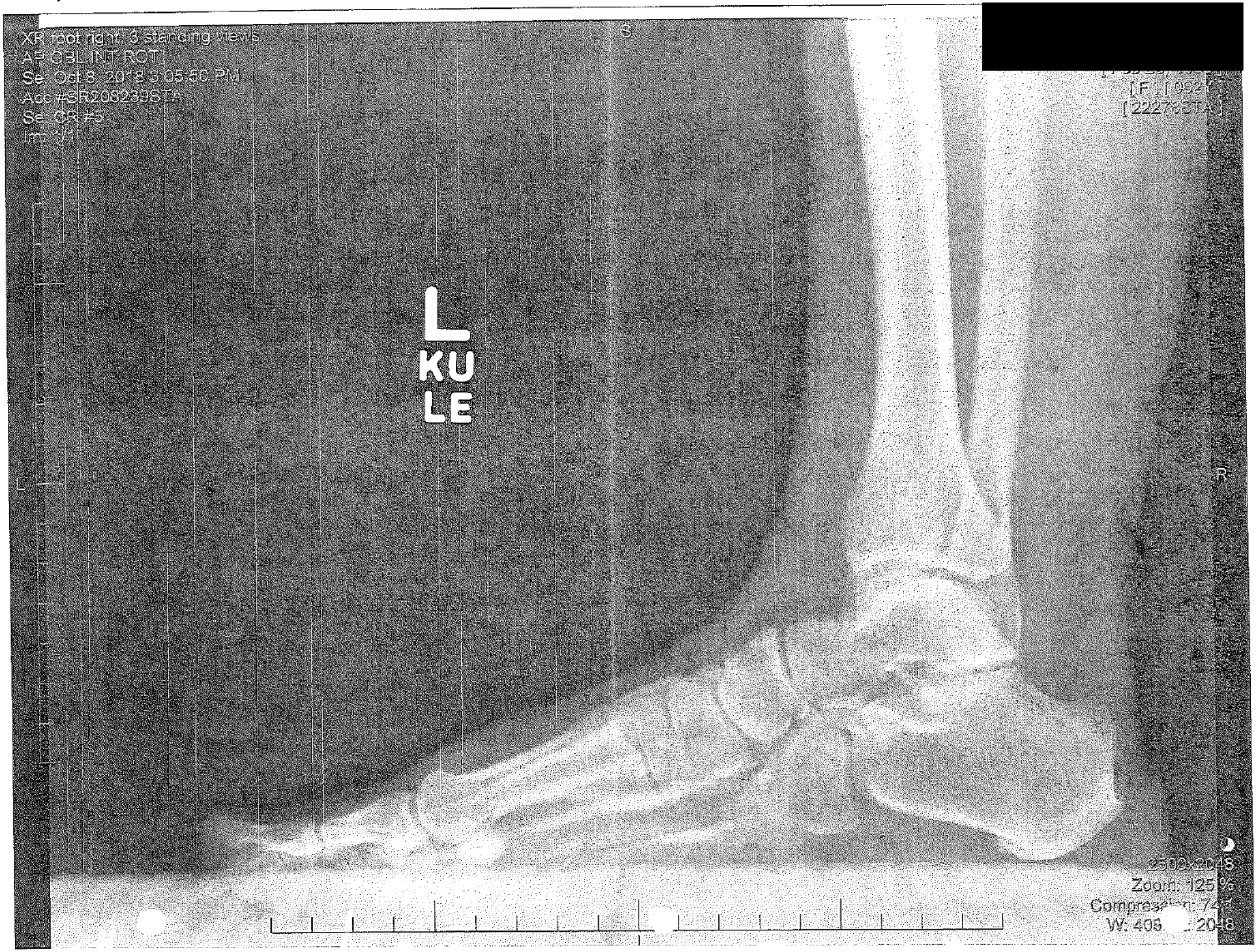

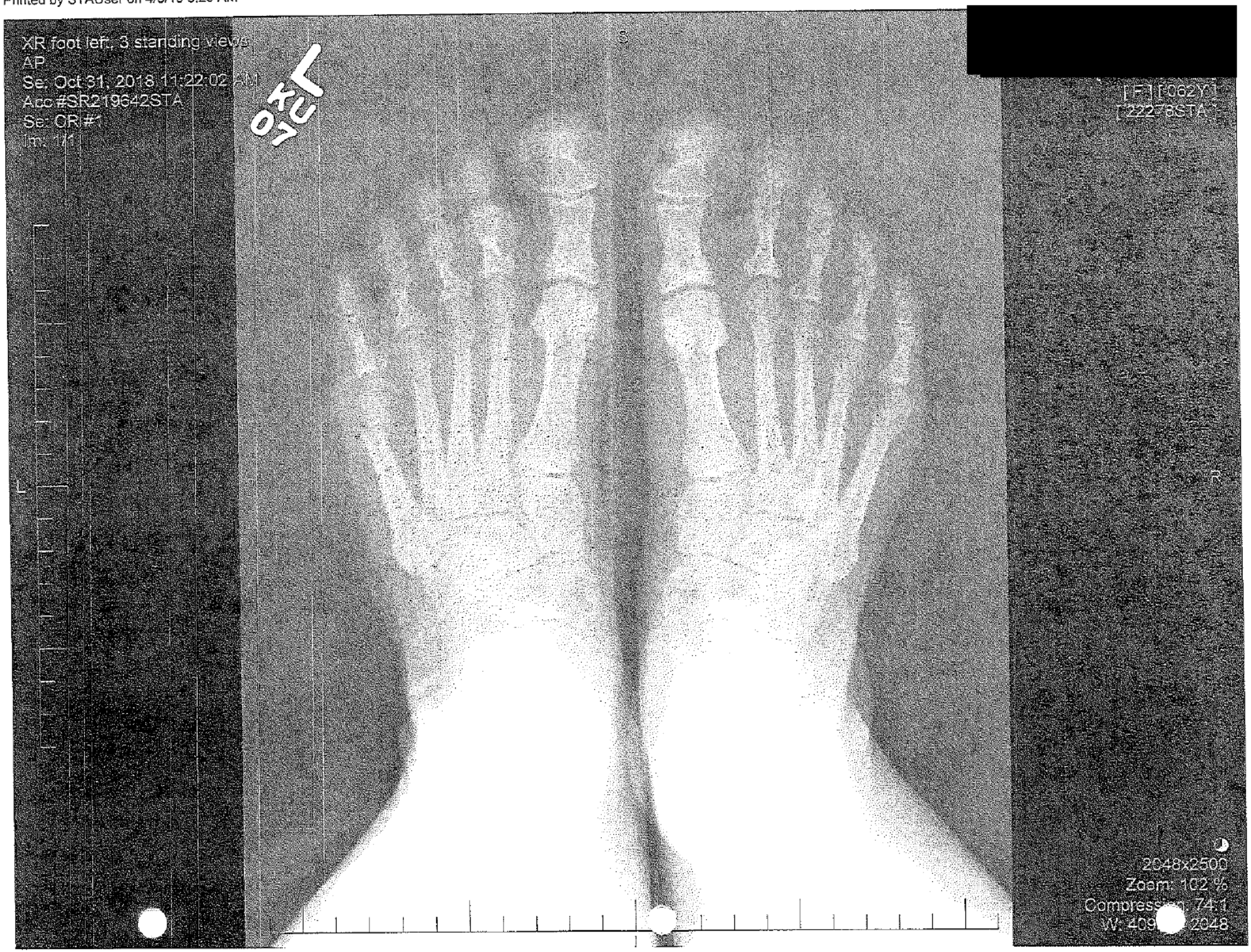
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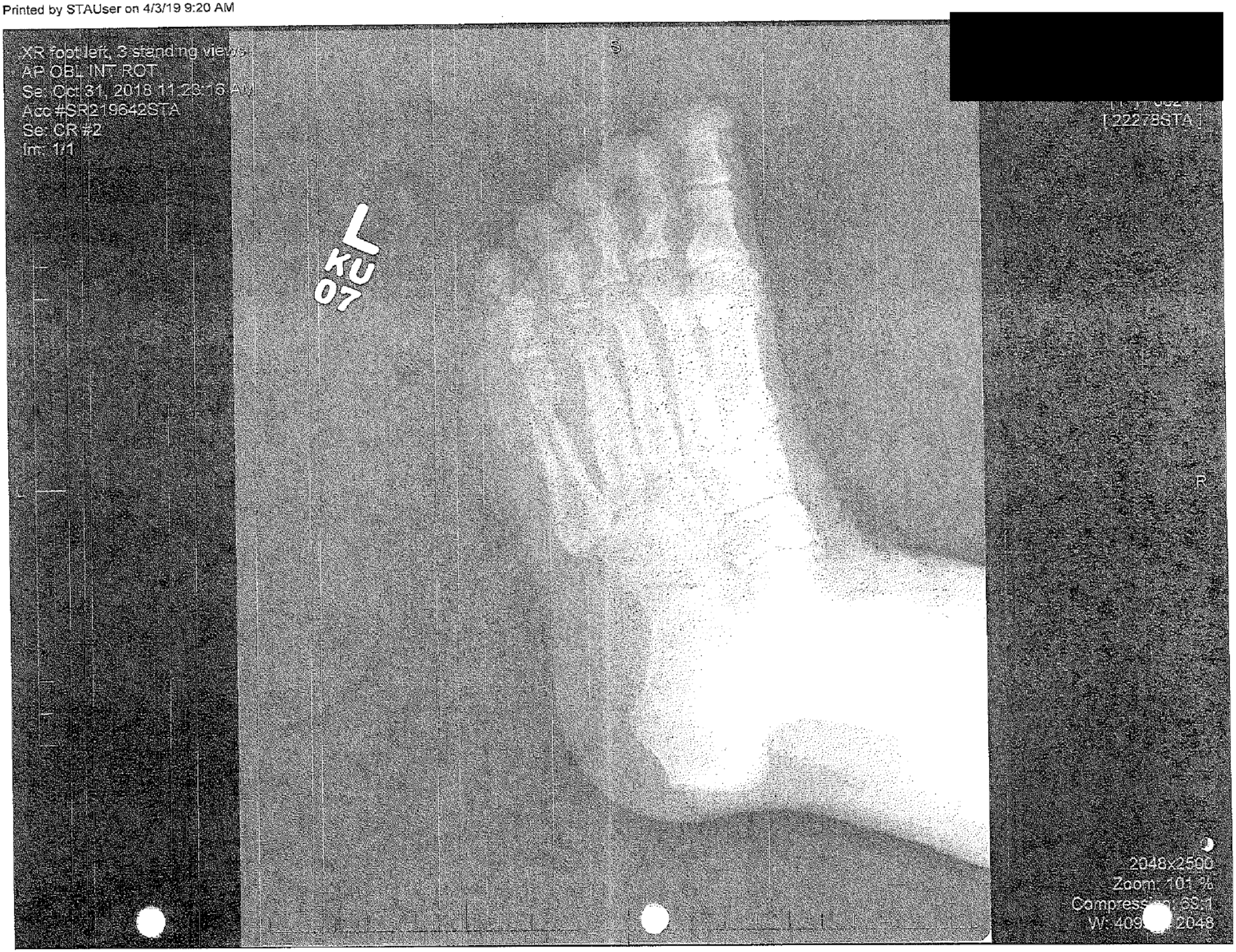

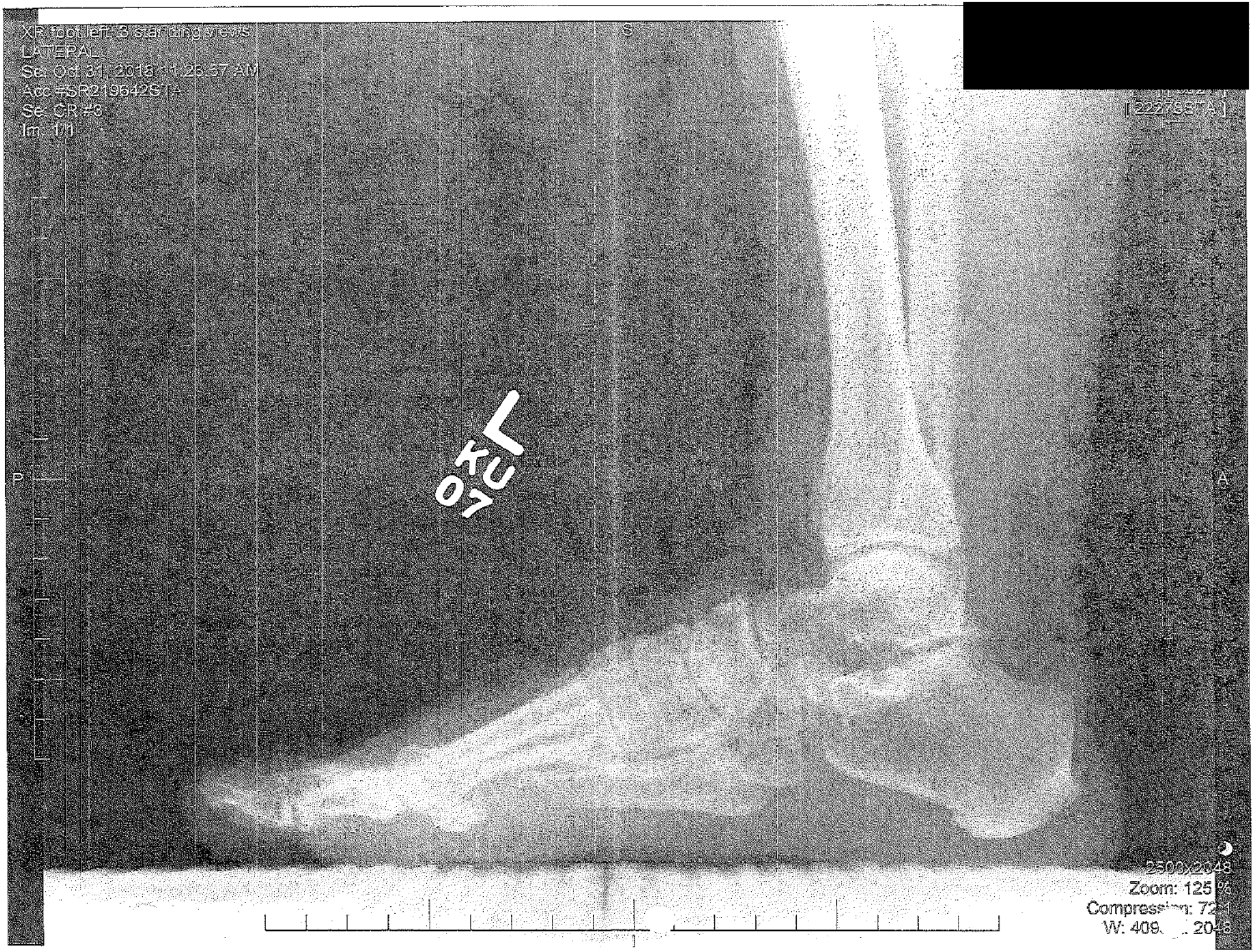
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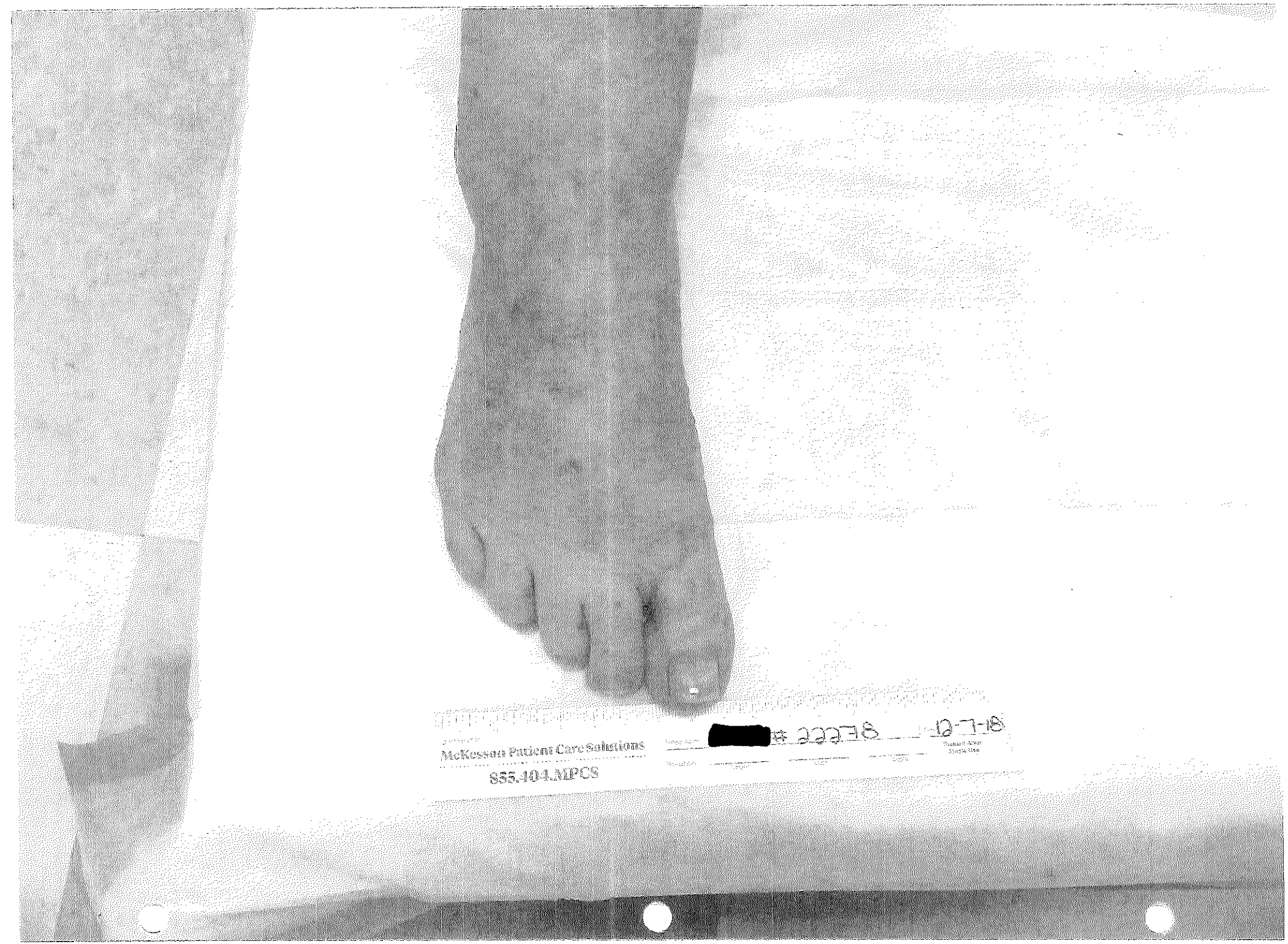
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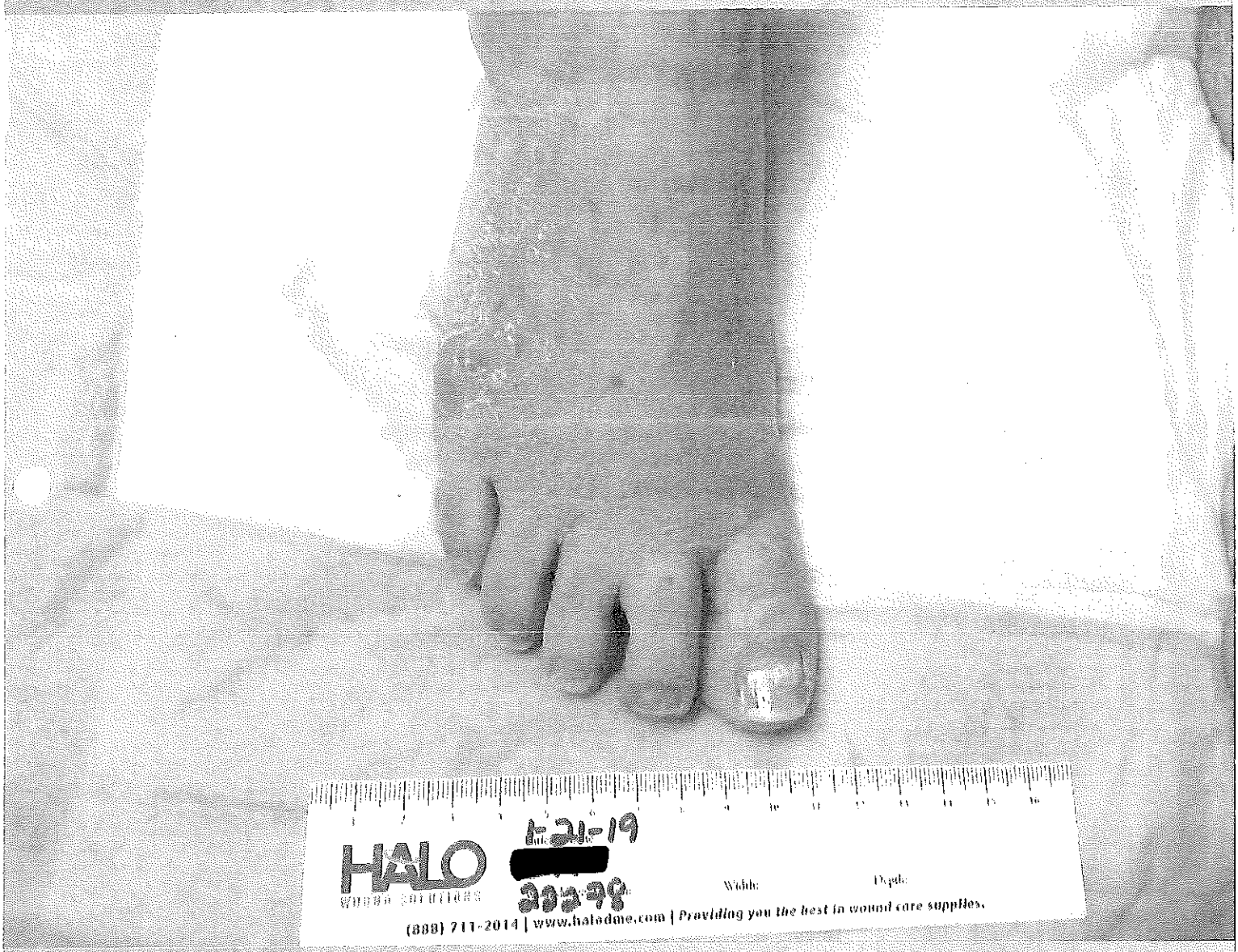
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PATIENT NAME: [redacted]
DATE OF BIRTH: [redacted]
PROVIDER: [redacted]
DATE OF SURGERY: 10/30/2018

PREOPERATIVE DIAGNOSIS
Painful tailor's bunion deformity, left foot.

POSTOPERATIVE DIAGNOSIS
Painful tailor's bunion deformity, left foot.

PROCEDURE PERFORMED

1. Tailor's bunion correction, left foot via 5th metatarsal osteotomy and partial ostectomy.
2. Fluoroscopic guidance of the above.

SURGEON
[redacted]DPM

ANESTHESIA
Local infiltration of 20 mL of 0.5% Marcaine mixed in 1:1 ratio with 2% lidocaine plain.

Nurse monitored sedation utilizing 4 mg of Versed, and 100 mg of fentanyl with 350 mL of fluid.

HEMOSTASIS
Not applicable.

RATIONALE FOR PROCEDURE
The patient is a 62-year-old female who has failed conservative intervention for symptomatic tailor's bunion deformity of the left foot, which included shoe gear changes, topical and injectable antiinflammatory therapy and therefore, was offered surgical correction with which she wished to proceed. She was provided options for percutaneous tailor's bunion correction as well as more traditional, and this is the surgical option that she chose. She was specifically advised that delayed union, increased edema, and the need for external compression support is important throughout the postoperative course. She acknowledged all risks as previously presented and her willingness to proceed.

PROCEDURE
While in the preoperative holding area, I personally initialed the site. The patient was then brought into the operating room and nurse anesthesia was provided. Left lower extremity was then prepped and draped in the usual manner for surgery and local infiltration anesthesia about the 5th metatarsophalangeal joint was provided. Attention was then directed to the 5th metatarsal head just proximal to the flare where a 0.5 inch incision was placed with a #64 blade and deepened to bone. Periosteal elevator used to allow for introduction of a hand rasp at the enlargement of the dorsolateral eminence. This was then hand-roughened and then with the use of a short Isham bur, the bony exostosis was reduced. Bone paste extruded from the site, which was then copiously irrigated.

Under fluoroscopic guidance, through the same incision with the use of a long Isham bur, and rotating osteotome, an osteotomy was performed from dorsal distal to plantar proximal from lateral to medial, and the distal head of the metatarsal shifted medially. This was checked on fluoroscopy and noted no complications and good alignment of the metatarsal head with reduction of the angulation. This site was copiously irrigated and then closed with 2 simple sutures of 4-0 nylon.

The surgical site was then instilled with 0.5 mL of dexamethasone and a compression bandage with Betadine soaked Adaptic, gauze, Kling, Coban was then provided. The patient tolerated the procedure extremely well, left

the operating room with no untoward surgical signs. All vital signs stable and is scheduled for followup in the office tomorrow.

[redacted]

Electronically signed by [redacted]
11/3/2018 12:58:26 PM

DD: 10/30/2018 1:35:50 PM DT: 10/30/2018 2:37 PM

[redacted]

PATIENT NAME: [redacted]
DATE OF BIRTH: [redacted]
PROVIDER: [redacted]
DATE OF VISIT: 10/31/2018
CLINIC ID NUMBER: 22278

REASON FOR VISIT
Postop.

DATE OF SURGERY
10/30/2018

HISTORY OF PRESENT ILLNESS
The patient is status post tailor's bunion correction. At 24 hours, she is very pleased. She has had no pain. She has taken no medication.

PHYSICAL EXAMINATION
Constitutional Exam: Well-developed female, alert, oriented, communicative, pleasant. Ambulation pattern is as expected. She is in a surgical shoe.

Left Lower Extremity Exam: Left foot exam, stable neurovascular status. Incision site pristine. Good correction of the preoperative deformity. No acute findings of erythema or warmth. No untoward surgical signs.

DIAGNOSTIC READINGS & INTERPRETATION
X-rays taken today, 3 views standing of the left foot, AP, lateral and oblique, reveal the osteotomy with medial displacement of the metatarsal head.

CLINICAL IMPRESSION
Excellent status post tailor's bunion correction.

TREATMENT PLAN

1. Sterile redressing provided with digital strap support. She is to stay in the surgical shoe, limit activity, and at her request I have provided a handicap sticker.
2. We will see her back next week.

[redacted]

Electronically signed by [redacted]
11/3/2018 12:58:29 PM

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PATIENT NAME: [redacted]
DATE OF BIRTH: [redacted]
PROVIDER: [redacted]
DATE OF VISIT: 11/30/2018
CLINIC ID NUMBER: 22278

REASON FOR VISIT
Bilateral feet.

HISTORY OF PRESENT ILLNESS
The patient is here today. She is status post Tailor's bunionectomy, which was performed on 10/30/2018. She is now four plus weeks. She is doing extremely well and wants to schedule the contralateral side. The right foot was not as bad as the left, and she is very pleased with the left and therefore wishes to proceed.

PFSH/REVIEW OF SYSTEMS
Read and reviewed without interval change from the 11/12/2018 visit.

PHYSICAL EXAMINATION
Constitutional: A well-developed female, alert, oriented, communicative, pleasant. She is ambulating in the surgical shoe.

Bilateral Lower Extremity Exam: Right Foot Exam: Tailor's bunion deformity is observed with a moderate lateral exostosis and varus rotation of the 5th digit. Neurovascular status is stable with good pedal pulses and tissue perfusion. Left Foot: Well-healed incision site with excellent reduction of the preoperative deformity. Very minimal swelling and only mild tenderness observed at the surgical site.

DIAGNOSTIC READINGS AND INTERPRETATION
X-rays taken today, 3 views standing of the left foot AP, lateral, and oblique revealed bone callus with the corrected positioning of the 5th metatarsal.

CLINICAL IMPRESSION

1. Right foot Tailor's bunion deformity.
2. Left foot status post Tailor's bunion correction.

TREATMENT TODAY

1. We can certainly schedule the right foot at her convenience. I can see her for preop.
2. On the left foot, she bring in a rigid sole shoe and she can transition gradually over the next week or two with ambulation to tolerance.
3. We will see her back for a more formal preoperative consultation.

[redacted]
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12/3/2018 9:29:35 AM

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PATIENT NAME: [redacted]
DATE OF BIRTH: [redacted]
PROVIDER: [redacted]
DATE OF VISIT: 12/12/2018
CLINIC ID NUMBER: 22278

REASON FOR VISIT
Postop.

DATE OF SURGERY
Right foot, 12/11/2018, left foot 10/30/2018.

HISTORY OF PRESENT ILLNESS
The patient is status post bilateral tailor's bunionectomy via ostectomy and osteotomy. She is doing extremely well on the left, but has noted some dry skin (slough of callus). On the right foot, she states she has had no pain after she removed a tight sock that was placed by one of the postoperative nurses. She is taking only Tylenol.

PFSH/REVIEW OF SYSTEMS
Read, reviewed without interval change.

PHYSICAL EXAMINATION
Constitutional: Well-developed female. Alert, oriented, communicative, pleasant. Ambulation pattern is stable. She is wearing the surgical shoe on the right and on the left she is in a regular casual slip-on shoe.

Right Foot Exam: Pristine appearance to the incision site. Neurovascular status stable. No untoward surgical signs. Excellent reduction of the deformity.

DIAGNOSTIC READINGS & INTERPRETATION
X-rays taken today, three views standing of the left foot, AP, lateral, and oblique reveal the osteotomy with medial relocation and good alignment. On the left bone callus is noted with a reduction of the deformity bilaterally.

CLINICAL IMPRESSION
Status post tailor's bunionectomy bilaterally.

TREATMENT PLAN

1. On the right foot, sterile redressing and digital stress support provided. On the left, I have trimmed some of the callus. All of it, however, was not "right" therefore I have recommended vitamin E.
2. We will see her back next week.

[redacted]
Electronically signed by [redacted]
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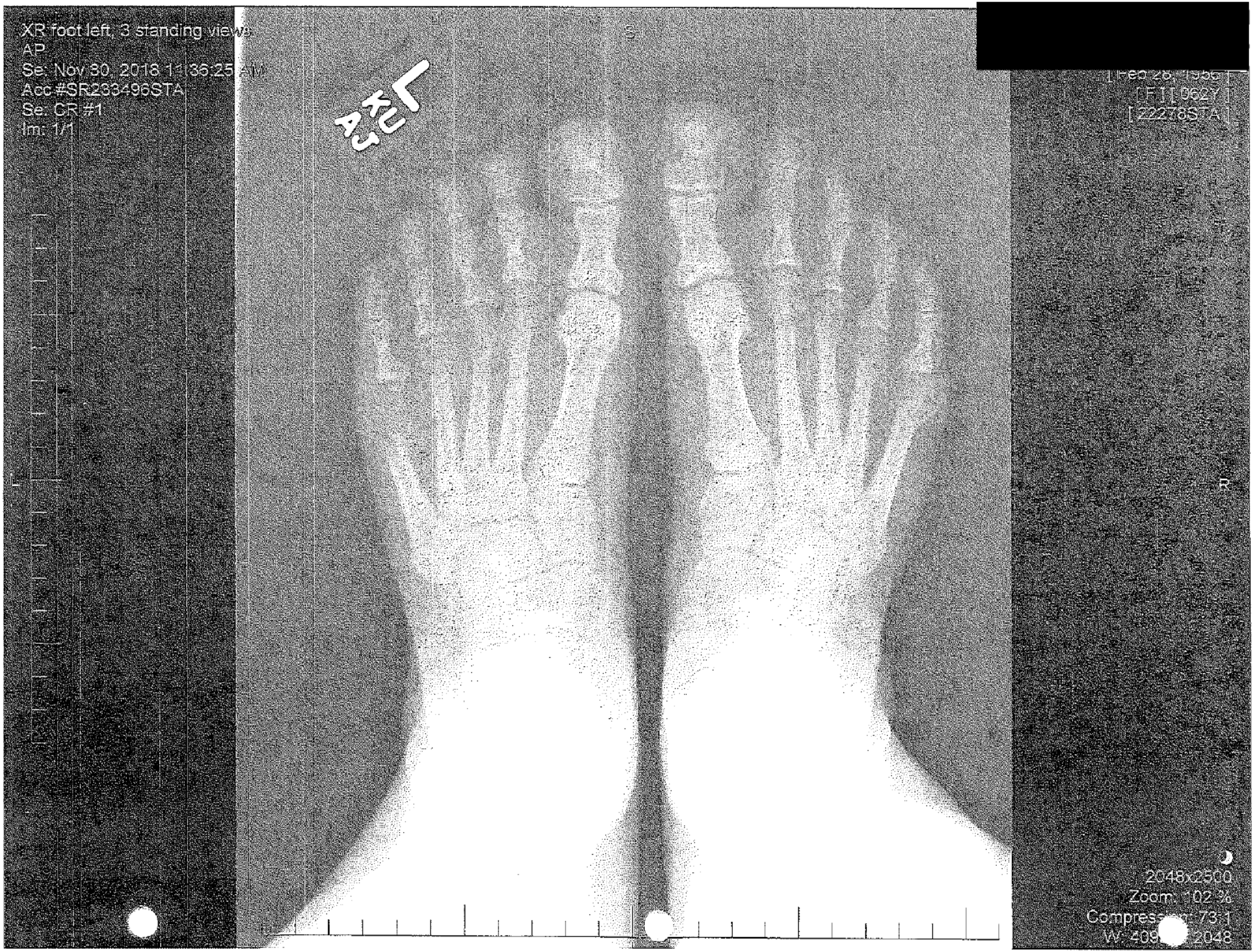
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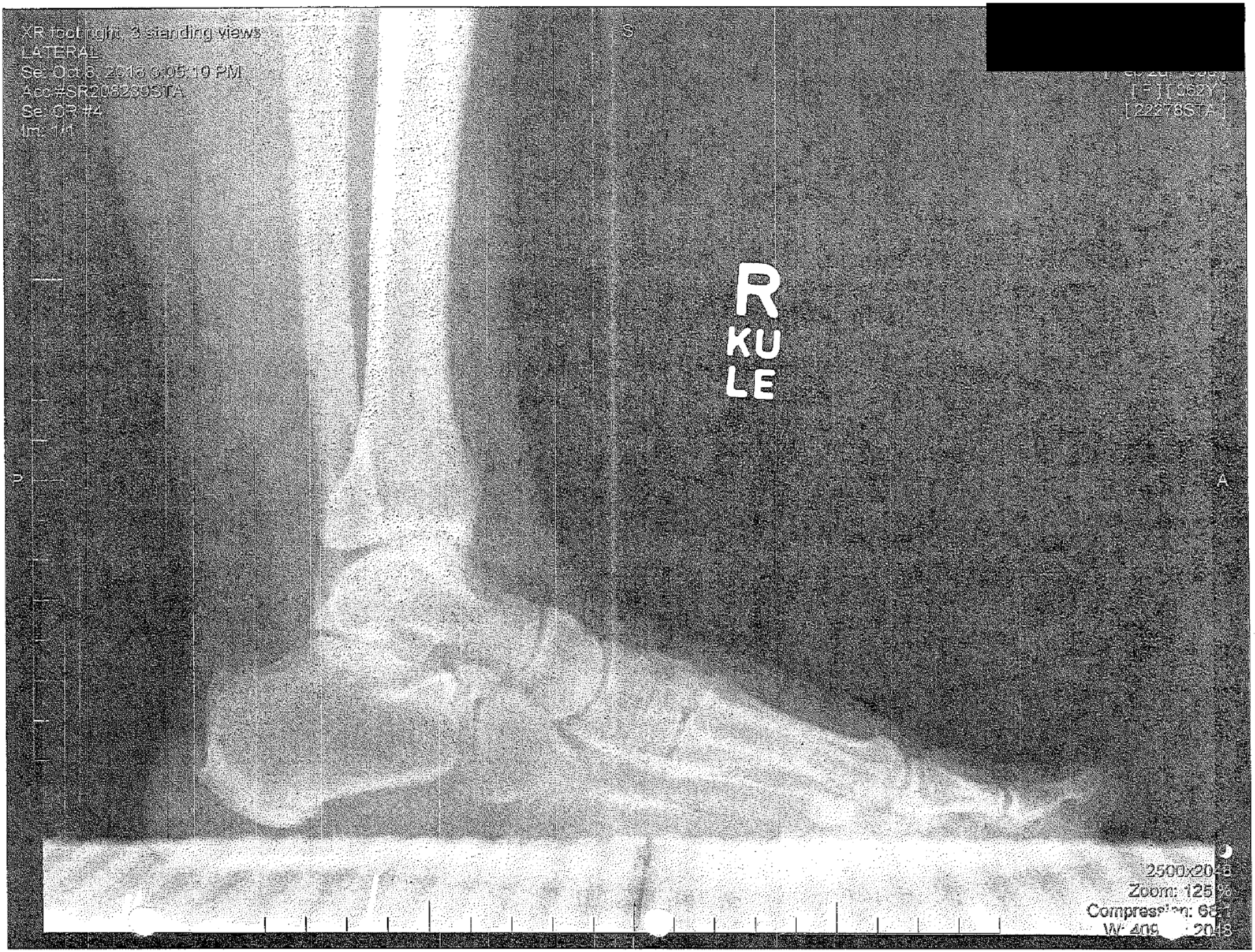
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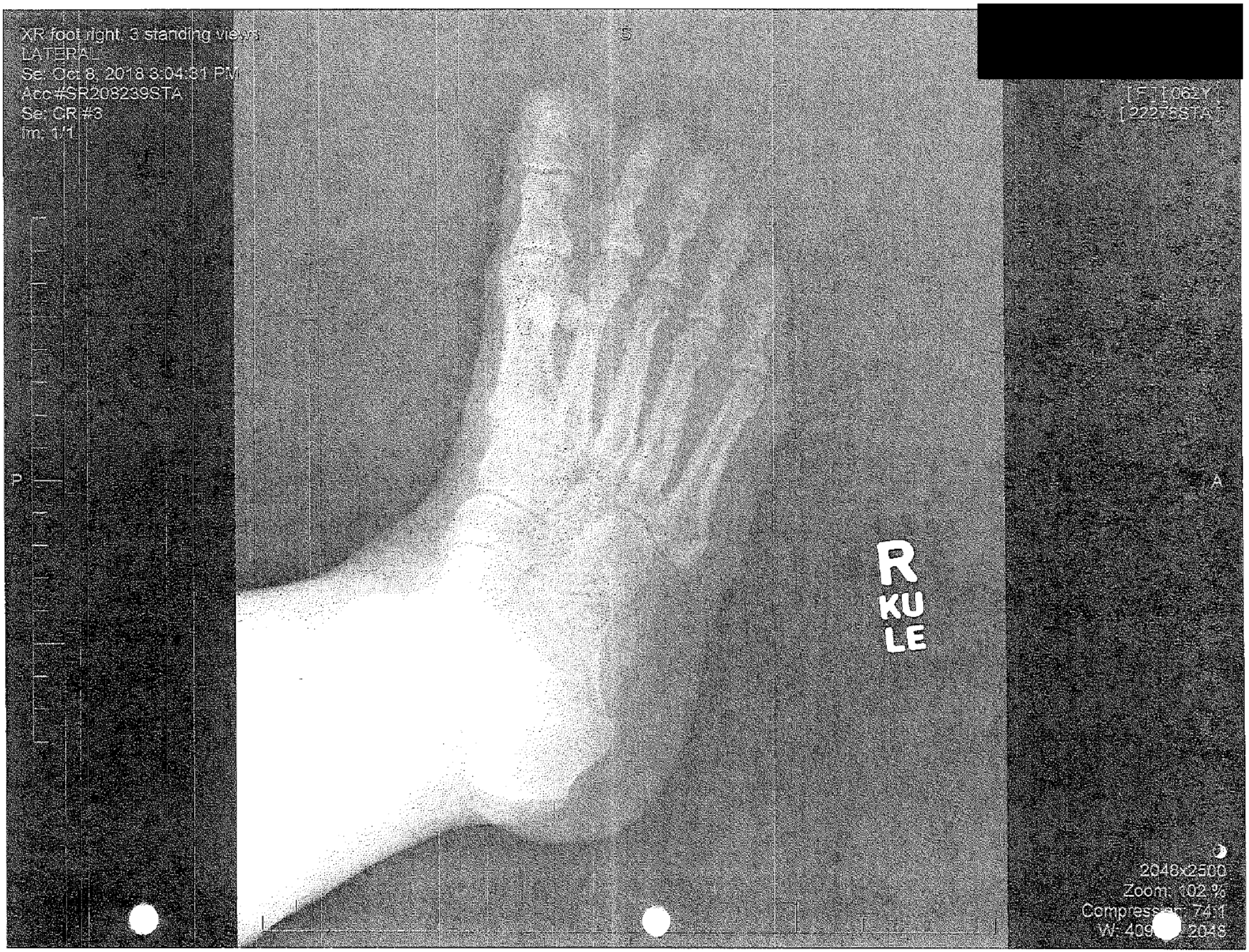
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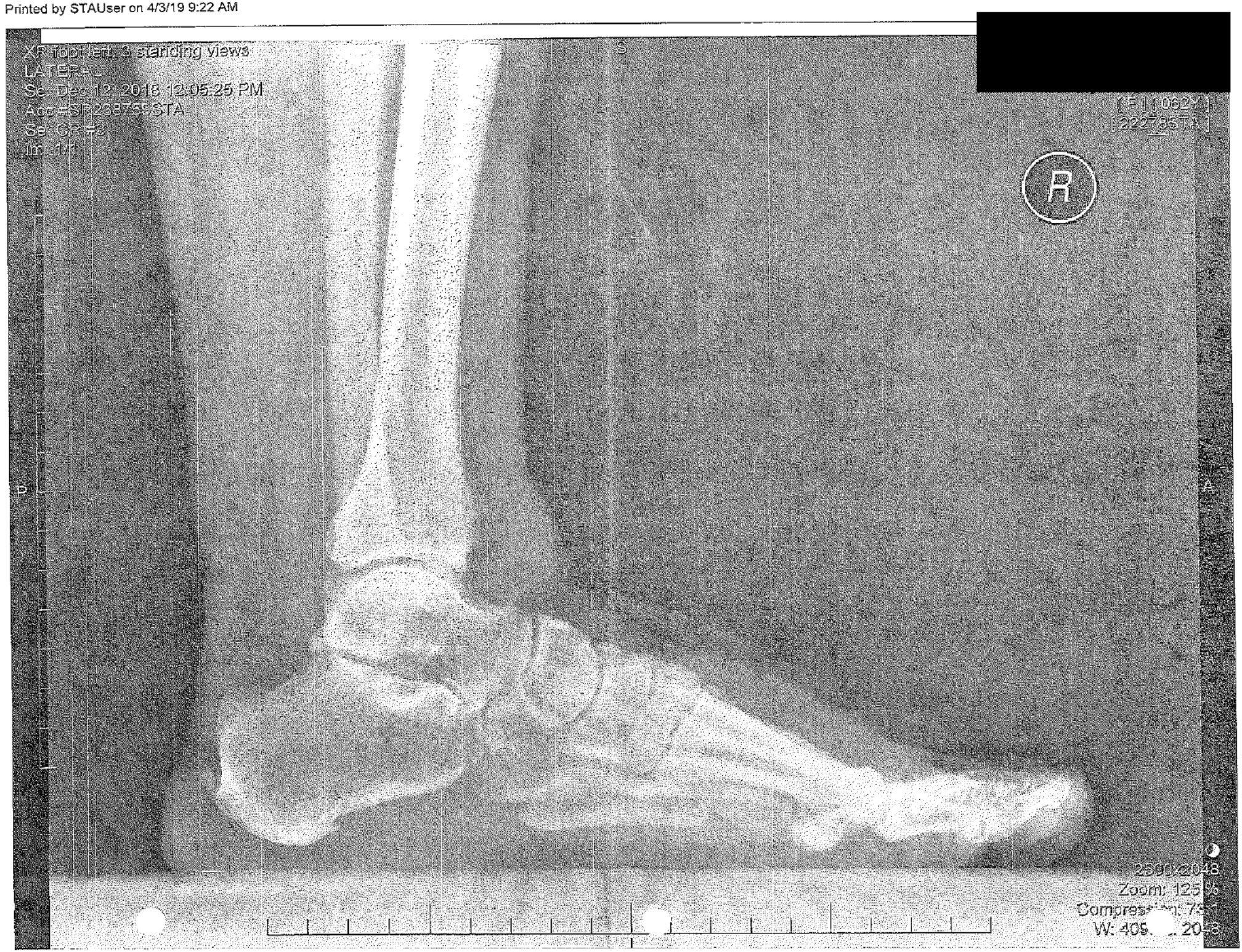
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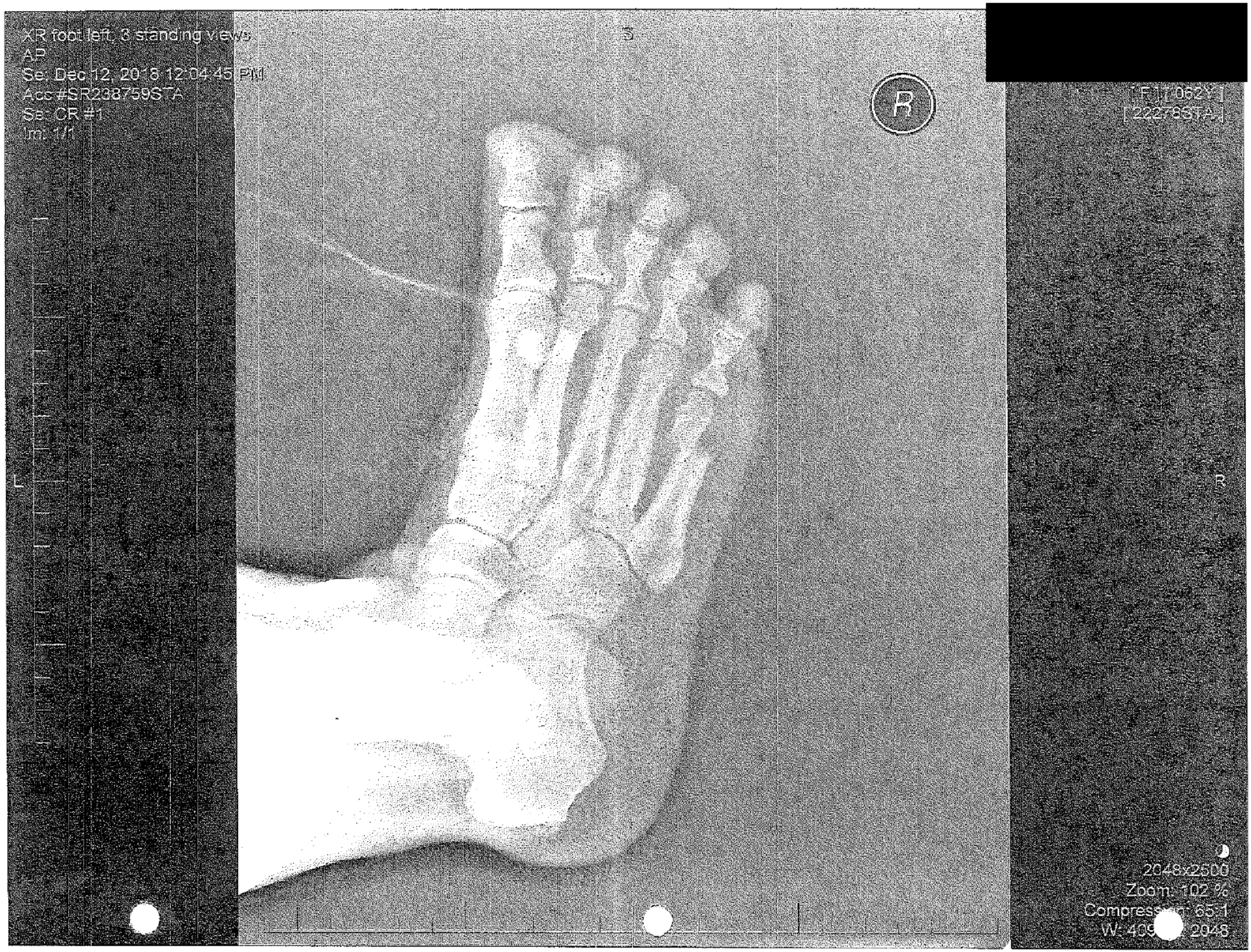
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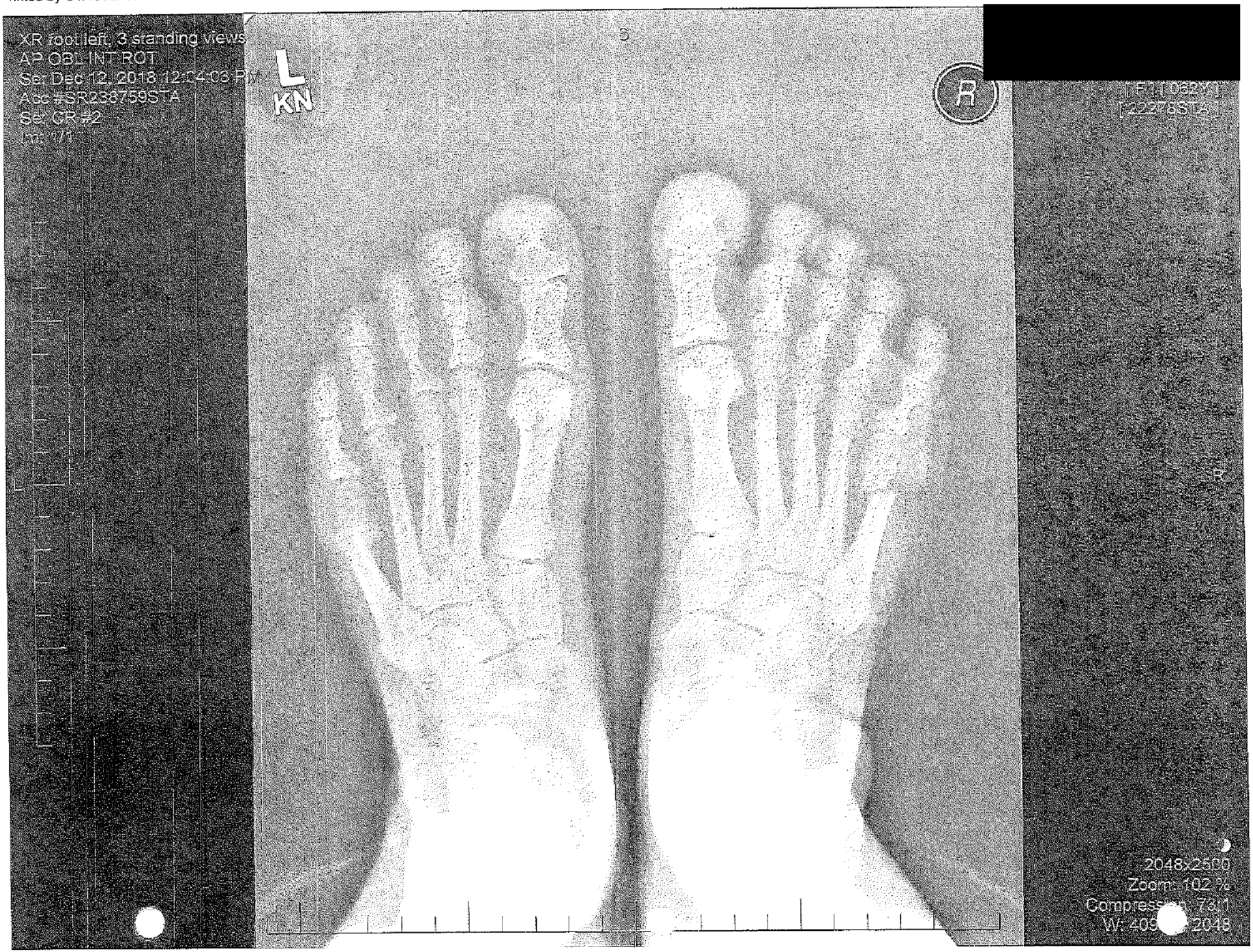

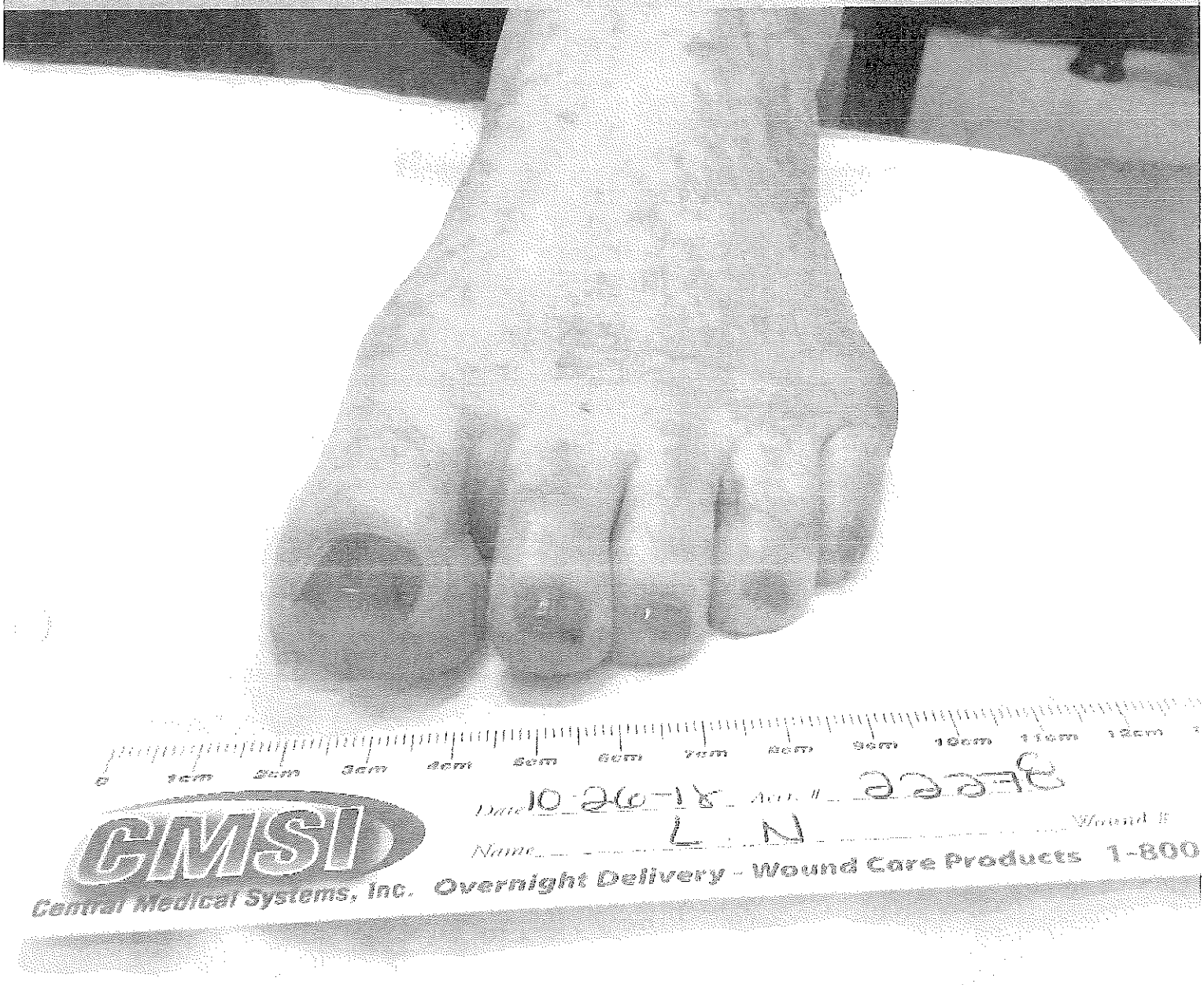
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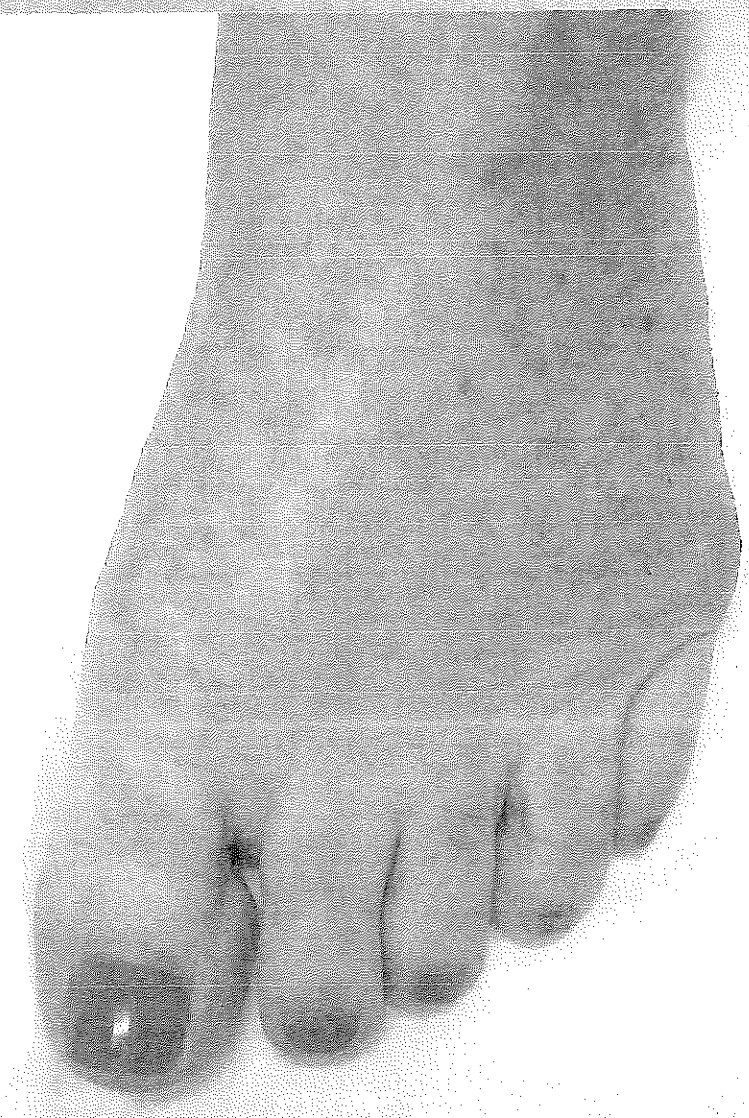

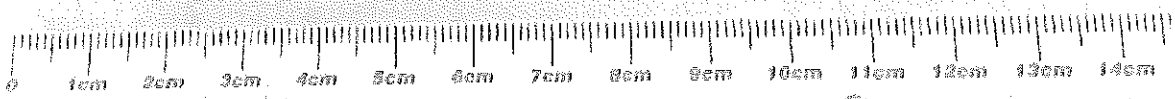

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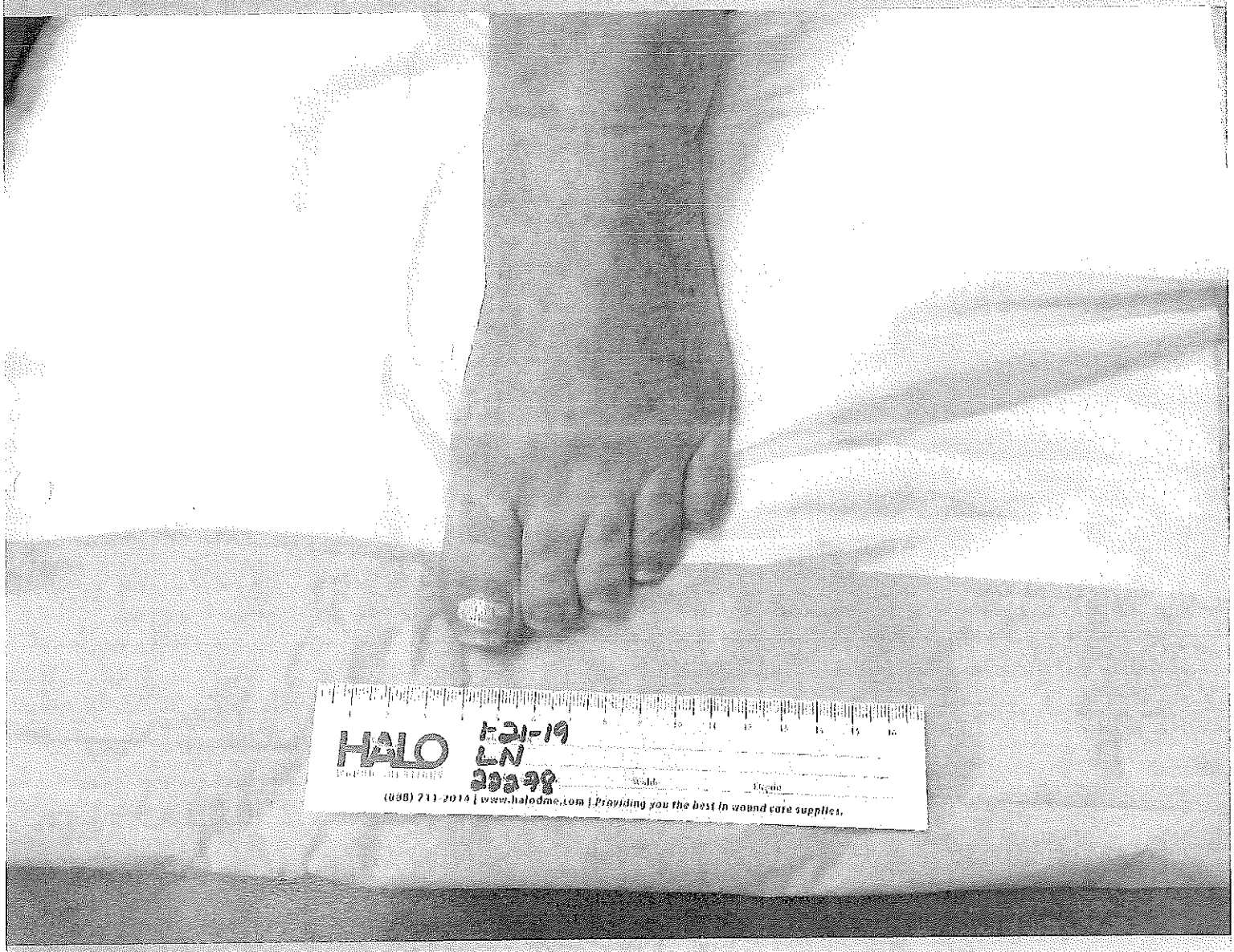
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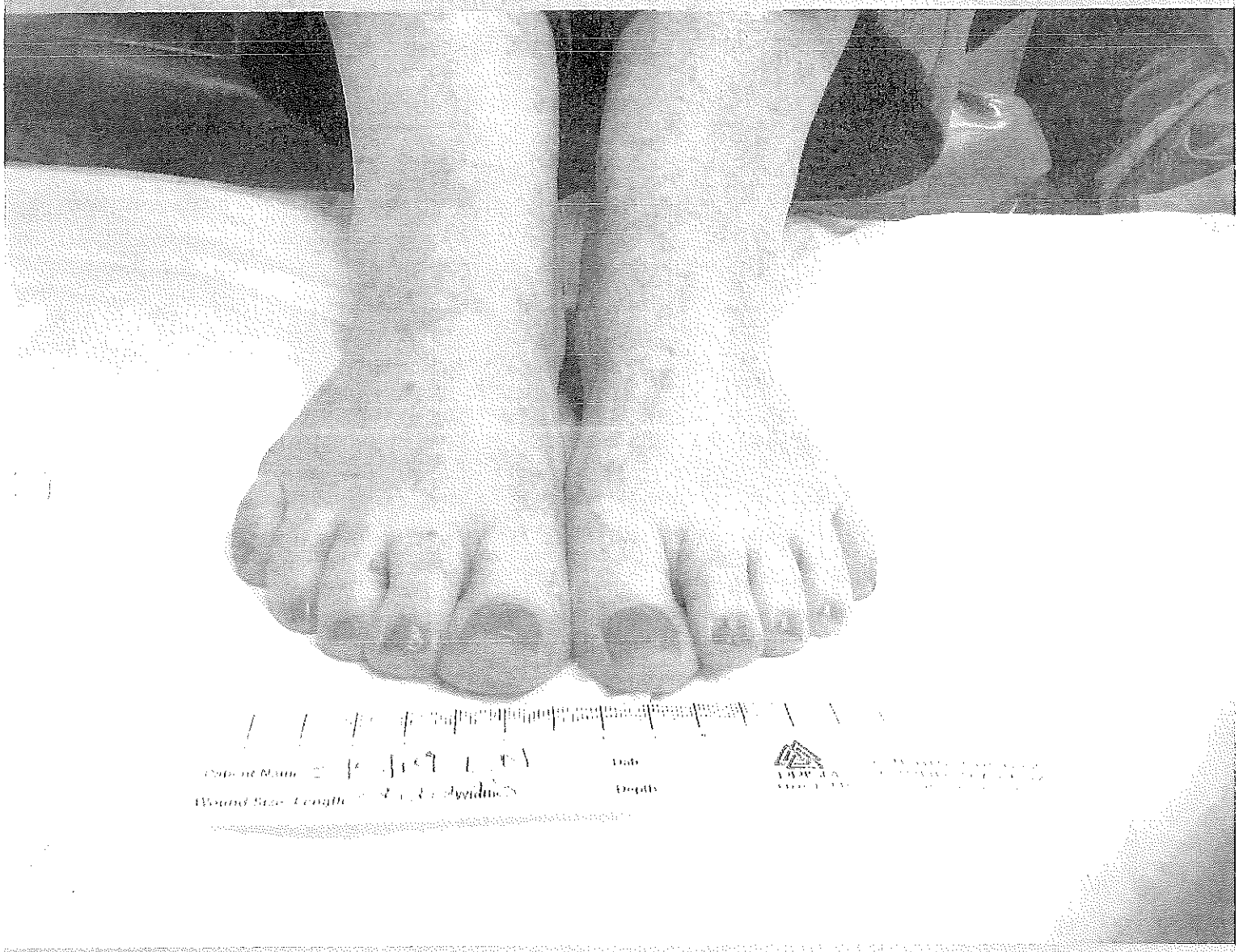


HARDWARE / FIXATION PROCEDURE CASE EXAMPLE

DOS: 09/01/2022

Progress Notes

Provider: [redacted] DPM

Date: 09/01/2022

Subjective:

Chief Complaints:

1. Zoom Consult for Bunion & Tendon Release LM.

HPI:

History of Present Illness:

The patient is a 29-year old male who was seen via zoom in for consultation in regard to his right foot. He has mild to moderate right foot bunion. From the pictures he sent, it looks like irritated and red. The patient reports he had a Lis franc surgery on 2013 and provides significant relief of the symptoms. The screws are still intact from the x-ray views.

The patient is calling from Yosemite National Park He states he is a rock climber and very active.

The patient has had bunion pain for a few years which has progressively gotten worse. She has tried over the counter orthotics, various pads, strapping devices, physical therapy, and other home remedies. She also tried shoe modification, going to wider shoes and more comfortable and stretchy shoes. All have failed. She at this point is only interested in having surgery. The pain is more frequent and becoming more intolerable.

Medical History:

Objective:

Assessment:

Plan:

Treatment:

1. Others

Notes:

1. The patient was recommended for a right foot bunionectomy. The condition, etiologies, options for care, treatment plan, and prognosis were discussed with the patient. Both conservative and surgical options for care were reviewed. All questions were answered.
2. It was explained to the patient that complications of the surgery might be an infection or non-healing bone.
3. I was able to show the patient pictures of the traditional bunionectomy scar versus the minimally invasive bunionectomy scar.
4. It was explained to the patient that the procedure is approximately 40 minutes to an hour. 5. It was explained to the patient that he will be prescribed Norco and Ultram for pain.
6. It was explained to the patient that he will be given surgical shoes for 4 weeks after surgery.
7. It was explained to the patient that he will be given crutches which can be used as needed.
8. It was explained to the patient that he can put 100% weight on his right foot depends on the patients pain tolerance.
9. It was explained to the patient that he will be refrain from activities such as running, jumping, cycling, yoga, and squatting which can give excessive pressure on the foot for 8 weeks.
10. It was explained to the patient that surgery will be done one foot at a time.
11. It was explained to the patient that bone healing is different from patient to patient.
12. It was explained to the patient to keep the foot dry in 10 days.
13. It was explained to the patient that there will be pins and screws that will hold the segment together. The bone will be cut and will be aligned. The pin will come out in 4 weeks and the screw will stay in 3 to 4 months. I am recommending removing the screw before 6 months. 14. It was also explained that after 4 weeks of pin

removal, the patient can wear regular shoes.
15. The patient was reassured that the screw will not interfere with her activities. However, if he feels that the head of the screw is under the skin. Then, we will remove it sooner.
16. The patient was advised to apply ice compression to the surgical site.
17. A discussion was held with regard to moving his right foot in an up and down motion which would likely help in the healing process.
18. It was also explained to the patient that the pain and swelling episodes that he will experience will be normal post-operative symptoms as the bone is not healed yet properly.
19. It was explained also to the patient that between 8 to 10 weeks, is when the bone completely heals and can resume back to wearing normal shoes and other work activities. 20. The patient will obtain medical clearance from his PCP.

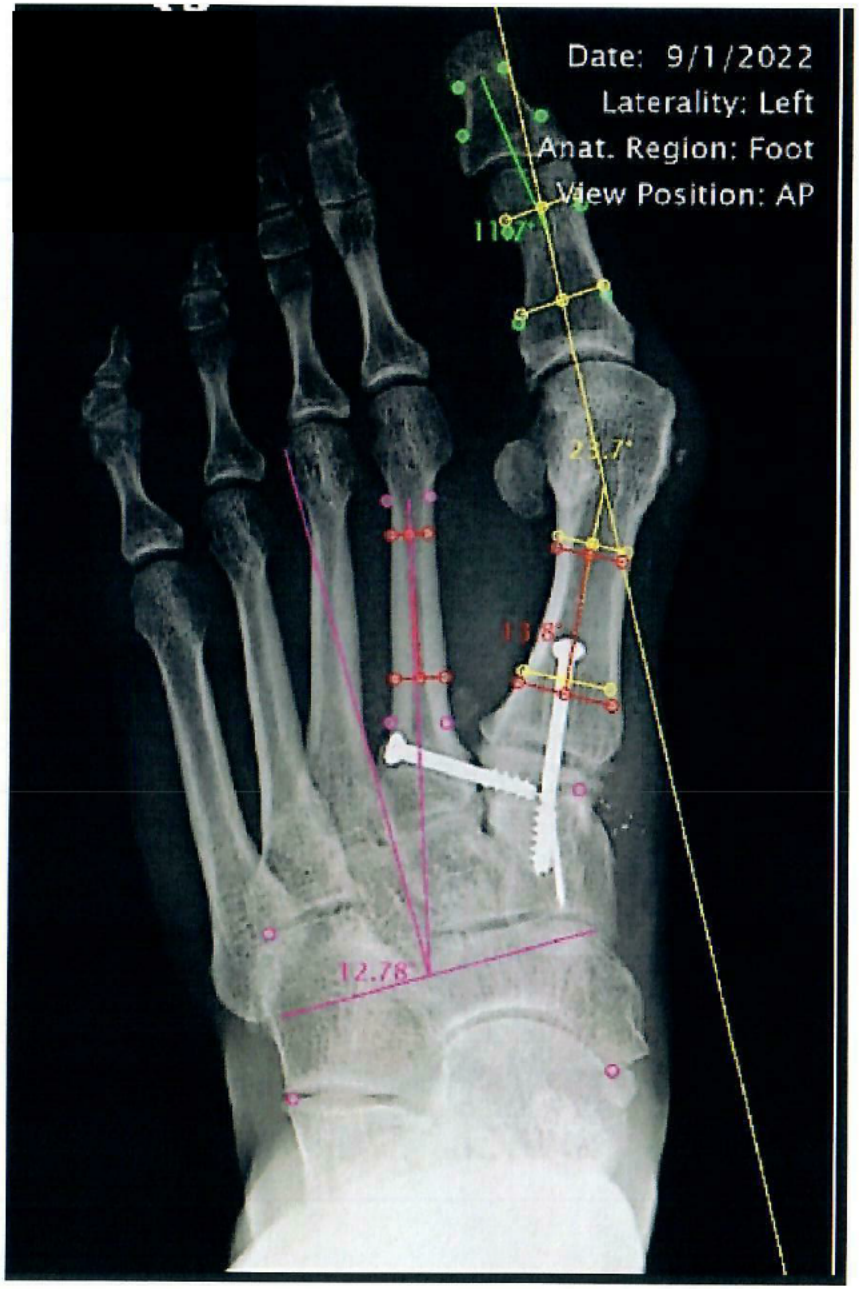
Images:

[redacted]

Electronically signed by [redacted] DPM

Provider: [redacted] DPM

Date: 09/01/2022


Date: 9/1/2022
Laterality: Left
Anat. Region: Foot
View Position: AP
11.87°
25.7°
13.8°
12.78°

DOS: 10/18/2022

Progress Note

Provider: [redacted] DPM
Date: 10/18/2022

Subjective:

Chief Complaints:

1. Ct, X-Rays, Prescription, Sx Consents, Vascular, BMD YC. 2. Consent Bunion.

HPI:

History of Present Illness:

The patient has had bunion pain for a few years which has progressively gotten worse. He has tried over the counter orthotics, various pads, strapping devices, physical therapy, and other home remedies. He also tried shoe modification, going to wider shoes and more comfortable and stretchy shoes. All have failed. He at this point is only interested in having surgery. The pain is more frequent and becoming more intolerable

The patient has no known drug allergies. The patient states he has no issues with anesthesias before. The patient states medical history is significant for arthritis.

Medical History:

Surgical History: Lis franc surgery 2013.

Family History: Maternal Grand Father: diagnosed with Unspecified essential hypertension. Maternal Grand Mother: diagnosed with Diabetes mellitus without mention of complication, type II or unspecified type, not stated as uncontrolled.

Social History: Smoking Are you a: non smoker. Drug/Alcohol Alcohol no.

Medications: None

Objective:

Physical Examination:

Musculoskeletal:

Foot and ankle Physical examination of the left foot shows pulses are intact. Neuro and sensory are intact. Light touch is intact. Capillary refill time is less than 3 seconds x5. The patient has an overpronated gait. There is a bunion deformity mild with mild subluxation MPJ. The hallux is in abductus and valgus position. There is pain on palpation on the medial aspect of the 1st metatarsal head. There is pain on palpation on 1st MPJ and extreme pain on extreme range of motion, dorsiflexion, and plantarflexion. There is mild pain palpating the fibular sesamoid. The patient range of motion is about (00) degree dorsiflexion and (00) degree plantarflexion. .

Assessment:

Assessment:

1. Bunion of left foot - M20.12 (Primary)

Plan:

Treatment:

1. Bunion of left foot

Notes: 1. The patient has tried all conservative treatments but failed. The patient was recommended for left bunionectomy. The condition, etiologies, options for care, treatment plan, and prognosis were discussed with the patient. Both conservative and surgical options for care were reviewed. All questions were answered.

2. I went over the details about the procedure. I went over his medical history, allergies, and the medication that he is taking. The patient will be having general anesthesia tomorrow. The mom is actually here with the patient helping him through the surgery and his case is tomorrow morning at 8 AM for left foot bunionectomy.
3. It was explained to the patient that complications of the surgery might be an infection or non-healing bone.
4. I was able to show the patient pictures of the traditional bunionectomy scar versus the minimally invasive bunionectomy scar.
5. It was explained to the patient that the procedure will be approximately 40 minutes to an hour.
6. It was explained to the patient that she/he will be prescribed Norco and Ultram for pain.
7. It was explained to the patient that he will be given surgical shoes for 4 weeks after surgery.
8. It was also explained to the patient that he will be given crutches which can be used as needed.
9. It was explained to the patient that he will not be able to drive with the right foot 6 weeks after surgery.
10. It was explained to the patient that he will be refrain from activities such as running, jumping, cycling, yoga, and squatting which can give excessive pressure on the right foot for 8 weeks.
11. It was explained to the patient that surgery will be done one foot at a time.
12. It was explained to the patient that bone healing is different from patient to patient.
13. It was explained to the patient to keep the foot dry 5 days after the surgery.
14. It was explained to the patient that there will be pins and screws that will hold the segment together. The bone will be cut and will be aligned. The pin will come out in 4 weeks and the screw will stay in 3 to 4 months. It will be recommended to remove the screw before 6 months.
15. It was also explained that after 4 weeks of pin removal, the patient can wean off surgical shoes and can start wearing regular shoes.
16. It was explained also to the patient that between 8 to 10 weeks, is when the bone completely heals and can resume back to wearing normal shoes and other work activities.

2. Others

Start HYDROcodone-Acetaminophen Tablet, 10-325 MG, 1 tablet as needed, Orally, every 6 hrs, 7 days, 28 Tablet, Refills 0 ; Start traMADol HCl ER Tablet Extended Release 24 Hour, 100 MG, 1 tablet, Orally, Once a day, 10 days, 10 Tablet, Refills 0 ; Start traMADol HCl Tablet, 50 MG, as directed, Orally, 2, 10 days, 20, Refills 0 . Notes: Discussed surgical options at this time since all conservative measures have been exhausted , All risks, complications and alternatives discussed , All questions answered , Discussed the etiology of the deformity in detail with the patient and possible causative factors. , Discussed all treatment options in detail with the patient ranging from conservative treatment to surgical intervention should conservative treatment fail , For informed consent, the procedure and perioperative period was discussed in detail, the most common risks and consequences and alternatives were discussed. , Signed consent in chart
I spoke to the patietn extensivly and did drawings on paper. I also showed patient x-rays from previous surgical procedures i have done. I went over every step. Patient undrestood and agreed to the surgery. I also have give patient a copy of my article that was published in the Journal of foot and ankle surgery . This artide explains the process for this procedure in details. Also gave the patient a list of other articles for very similar procedure which is the minimally invasive bunion procedure.

1. Modified Percutaneous Hallux Abductovalgus Correction. [redacted]

J Foot Ankle Surg. 2016 Nov - Dec;55(6):1336-1342. doi: 10.1053/j.jfas.2016.07.006. Epub 2016 Sep 3.

2. **Percutaneous** distal metatarsal osteotomy for correction of hallux valgus. [redacted]

J Bone Joint Surg Am. 2005 Jun;87(6):1191-9.

3. Percutaneous distal metatarsal osteotomy versus distal chevron osteotomy for correction of mild-to-moderate hallux valgus deformity. [redacted]

Arch Orthop Trauma Surg. 2012 Nov;132(11):1539-46. doi: 10.1007/s00402-012-1585-5. Epub 2012 Jul 22.

4. **Percutaneous Triple** and **Double** Osteotomies for the Treatment of Hallux Valgus. [redacted]

Foot Ankle Int. 2017 Feb;38(2):159-166. doi: 10.1177/1071100716670403. Epub 2016 Oct 1.

Provider: [redacted] **DPM** **Date: 10/18/2022**

5 **Percutaneous** hallux valgus treatment: Unilaterally or bilaterally. [redacted]

Foot Ankle Surg. 2016 Dec;22(4):248-253. doi: 10.1016/j.fas.2015.11.002. Epub 2015 Dec 9.

Imaging:
Imaging: Fluoroscopy

X-ray of the left foot shows a significant hallux abductus. The patient has an enlarged medial head of the 1st metatarsal. The hallux and 2nd digits are budding against each other and the hallux is slightly overlapping the 2nd digit. One can note, there is an increase in IM angle. The patients IM angle is about 14 degree, the hallux abductus angle is about 24 degree, and the hallux inter phalangeus angle is about 11 degree. (MAA) Metatarsus adductus angle 12.78 degree, PASA angle (Proximal Afiicular Set Angle) is about (00) degree, DASA angle (distal articular set angle) is about (00) degree. The sesamoidal positions 4. There is subluxation of the 1st MPJ laterally. There is cortical thickening of the medial cortex of the 2nd metatarsal. The patient has slight subluxation of the 1st MPJ laterally. There is a little bit of joint space narrowing. He also has hardware present at the base of the 1st metatarsal from the previous surgery he had which seems to be a Lisfranc injury.

Procedure Codes: 76000 Fluoroscopy Exam Up to an hr, Modifiers: 59 , 76000 Fluoroscopy Exam Up to an hr, Modifiers: 59

Follow Up: prn. prn

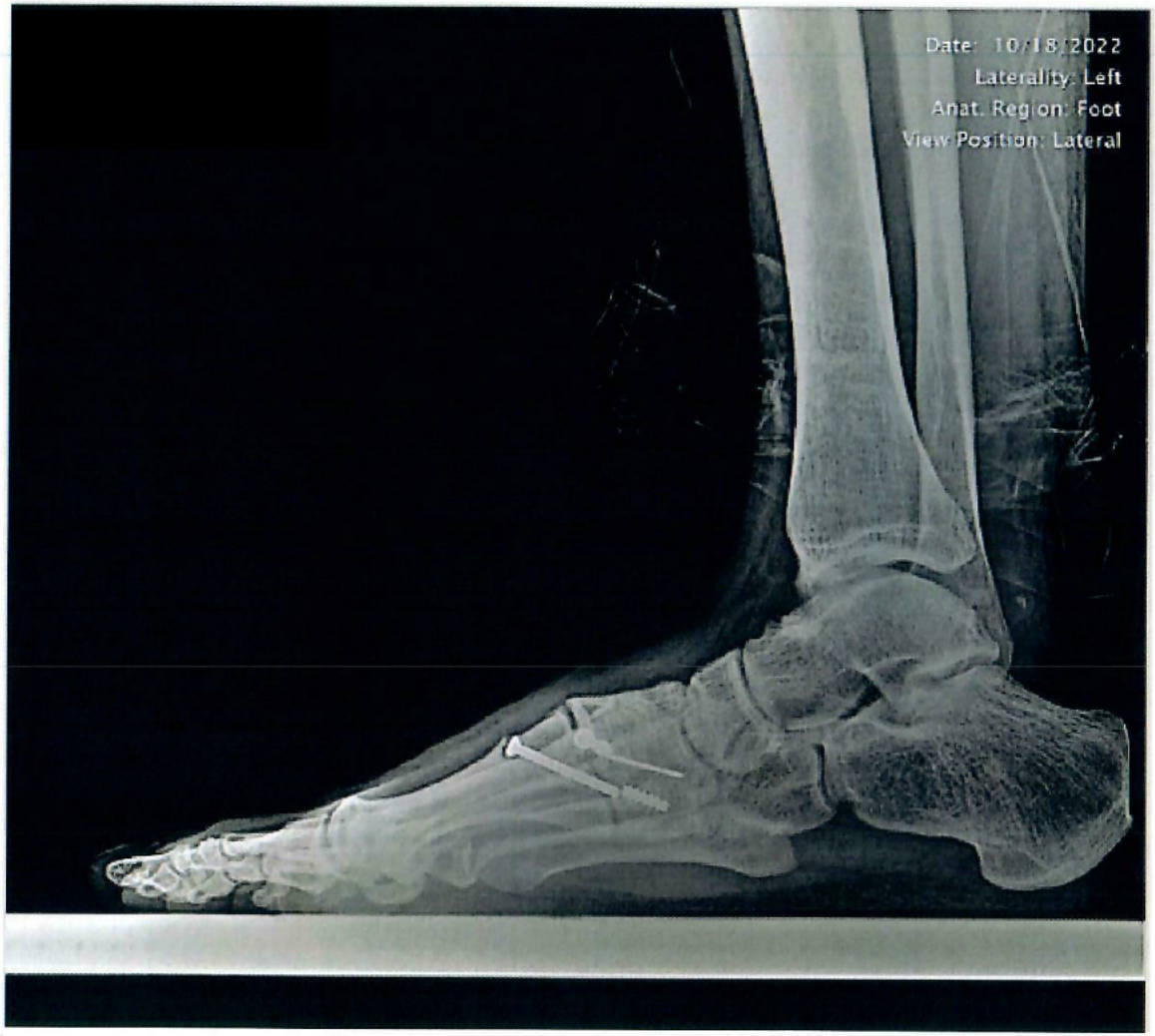
Images:

[redacted]

Electronically signed by [redacted] DPM

Provider: [redacted] DPM

Date: 10/18/2022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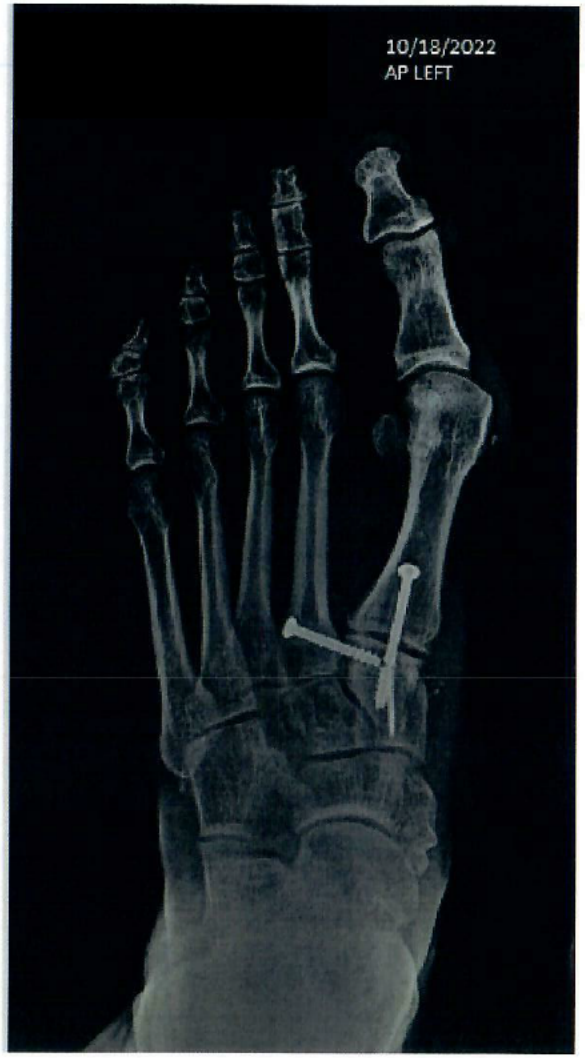
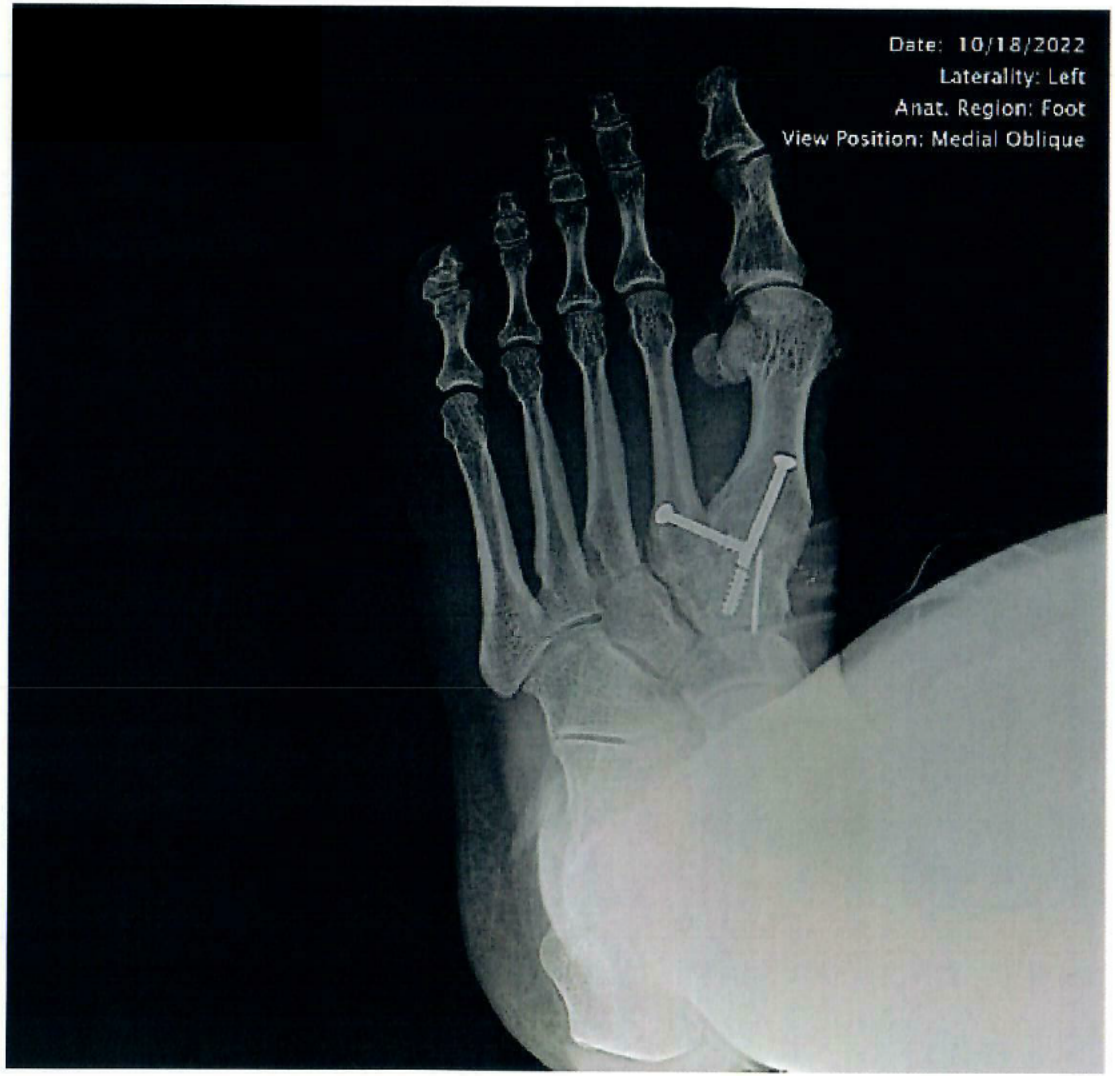
Anat. Region: Foot
View Position: Lateral


10/18/2022
AP LEFT


Date: 10/18/2022
Laterality: Left
Anat. Region: Foot
View Position: Medial Oblique

Operative Report

Patient Name:

Facility: DOS: 10/19/22.

Patient DOB: [redacted]

Surgeon: [redacted] DPM

Planned Procedure:

1. Percutaneous Bunionectomy ' with fixation. Left

Pre Op Dx:

1. Bunion Left

Post Op Dx: SAME

Anesthesia: Genral

Anesthesiologist: [redacted]

EBL: Minimal

Flouroscopy time : .9 min

Bunion Procedure

Patient was brought into the operating room and put on the operating table in a supine position. Following general anesthesia, local anesthesia was administered to the patient foot by menas of injection at the base of the first metatarsal (please see chart for details this was)

Attention was directed to the first metatarsal head and neck. This entire surgery was performed under fluoroscopy observation. The first percutaneous incision is carried out at the distal metaphysis of the first metatarsal on the medial side, which is the site of the osteotomy. I utilized a .062 K-wire to determine the level of my osteotomy in this region. I performed a technique called " Multiple Drill hole" to outline my osteotomy level. I then utilized an osteotomy to performed through the sub-capital region of the first metatarsal. The cut is made in a single plane, perpendicular to the axis of the shaft of the first metatarsal in the sagittal plane. I displace the osteotomy slightly in plantar position to the hallux and the metatarsal

head. Further- more, the metatarsal head was rotated in the axial plane as needed to correct the rotational components of the deformity.

The percutaneous displacement of the first metatarsal head was achieved with the use of a self made guide wire which is a bent grooved probe, manufactured from a stainless-steel cylindrical rod, measuring 7 mm in diameter. The distal edge of the device is smooth and is bent over a distance of about 4 cm.

A small stab incision was made at the junction of the metatarsal cuneiform to allow the metatarsal to move slightly medial.

A Primary point of fixation was used by means of screw with diameter of 4.0 Callulated from Arthrex, which was inserted from proximal medial to distal lateral going from the shaft to the head of the first metatarsal. The head of the screw was as flush as possible to the bone, thus preventing irritation. This point of fixation meant to be kept in the bone long term.

This osteotomy was a Transverse osteotomy at the level of the head and neck junction. Due to the nature of this osteotomy a secondary fixation was used by means of a second screw with Diameter 4.0 Callulated fully threaded screw from Arthrex, which is inserted from proximal medial dorsal at the level of the base of first metatarsal to distal lateral plantar. This pin stops inside the head of the first metatarsal.

Please refer to OR chart for the length of the screws

"The patient will be returning to the operating room for the next staged procedure which will be the removal of the implanted buried Steinman pin and manipulation of the 1st MPJ, if necessary".

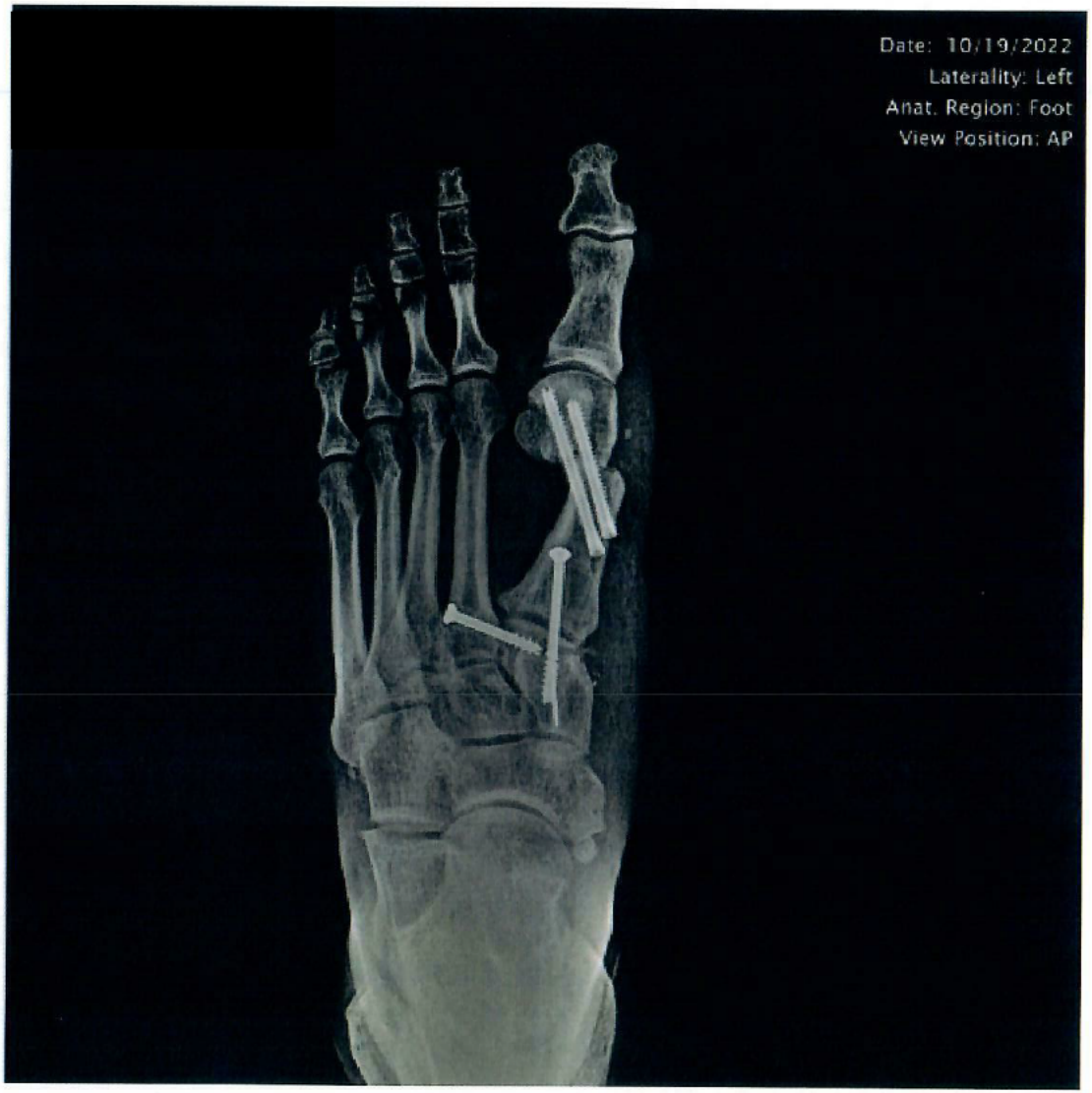
Pt tolerated anesthesia and surgery well and was escorted to PACU with VSS and NVSI to the foot.

At the end of the procedure the anesthesiologist was asked to give a total ankle block for post surgery pain control.

Patient was given a surgical shoe and crutches. Even though this osteotomy is very stable with 2 points of fixation. She was told to be partial weight bearing. The surgical shoe which is a DARCO had a Peg assist insole. The peg assist insole was modified for a first ray cut out to offload the head of the first metatarsal when patient ambulating. Patient was told to use this shoe and only this shoe for the next 4 weeks. Patient was told if he or she does not use this shoe the osteotomy may shift and result in future none healing and further surgeries.

Dr. [redacted] DPM

Date Signed: 11/02/2022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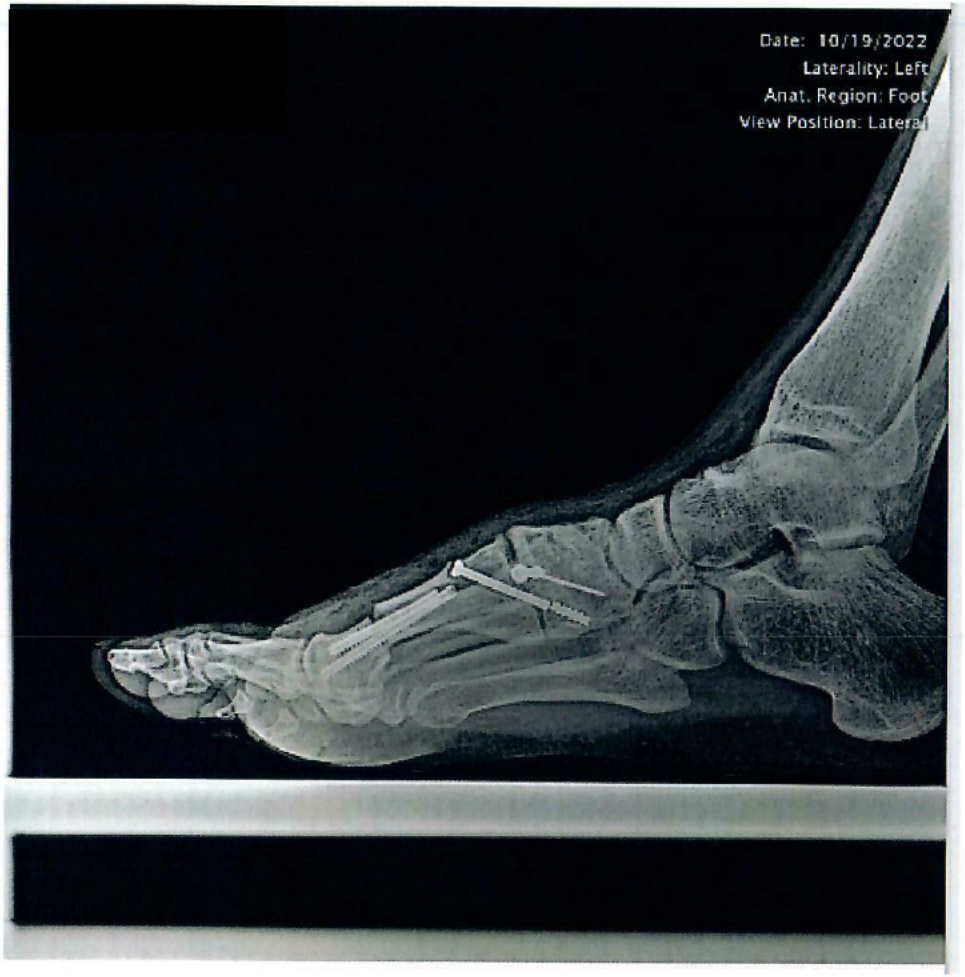
Anat. Region: Foot
View Position: AP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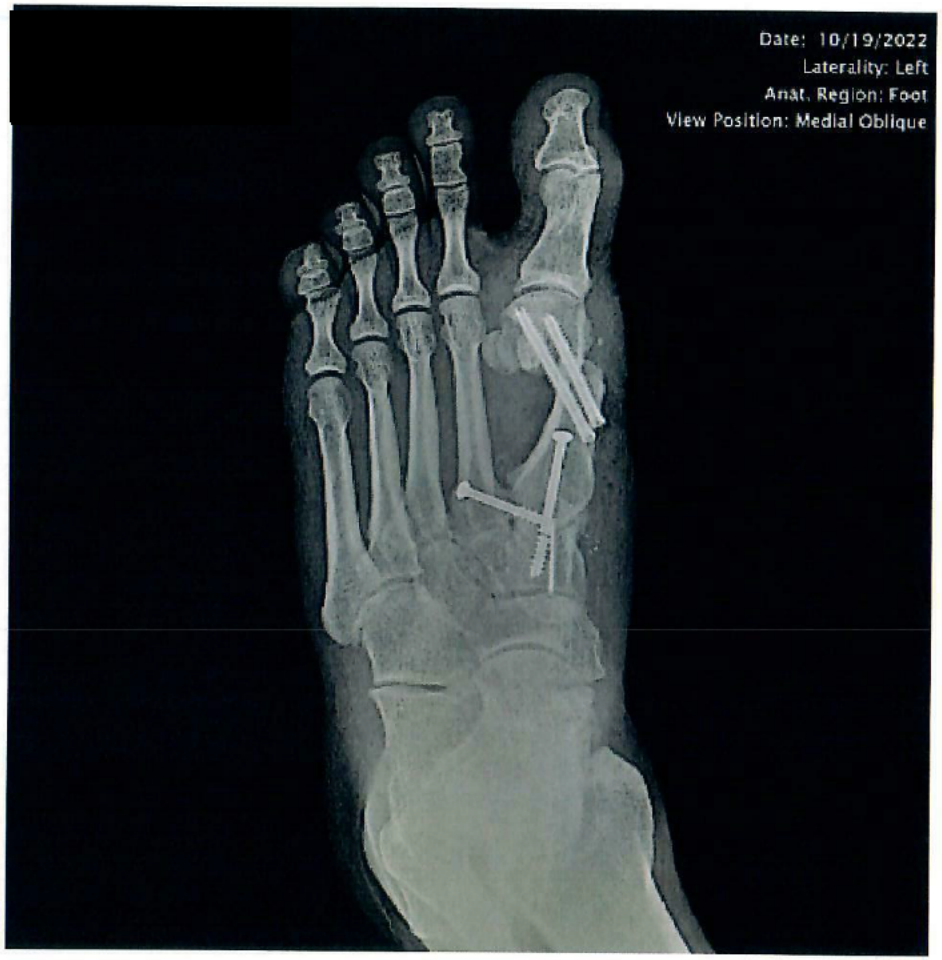
Anat. Region: Foot
View Position: Lateral


Date: 10/19/2022
Laterality: Left
Anat. Region: Foot
View Position: Medial Oblique

DOS: 10/21/2022

Progress Notes

Provider: [redacted] DPM

Date: 10/21/2022

Subjective:

Chief Complaints:

1. Post Op Left Bunionectomy YC.

HPI:

History of Present Illness:

The patient presents for follow up status post left foot bunion AMI procedure on 10/19/2022. He is doing well.

Patient denies fevers, chills, nausea, vomiting, wound drainage, or complications and is feeling better.

Medical History: Medical History Verified.

Surgical History: Lis franc surgery 2013, left bunionectomy 10/2022.

Family History:

Patient indicated family medical history with Diabetes Mellitus mentioned Grandmother and Grandfather.

Social History: Smoking Are you a: non smoker. Drug/Alcohol Alcohol no.

Medications: Taking HYDROcodone-Acetaminophen 10-325 MG Tablet 1 tablet as needed Orally every 6 hrs , Taking traMADol HCl ER 100 MG Tablet Extended Release 24 Hour 1 tablet Orally Once a day , Unknown traMADol HCl 50 MG Tablet as directed Orally 2

Allergies: N.K.D.A.

Objective:

Physical Examination:

Musculoskeletal:

Foot and ankle Dermatological: Left foot examination shows Incision is closed, with no signs of any open lesions. Mild edema. No erythema. No drainage anywhere. No cellulitis. The temperature on the skin is normal.

Neuro and Vascular: Pulses are intact. Capillary filling time is less than 3 seconds on the digits to the surgical foot. There is no pain on palpation. Neurosensory is slightly decreased around the surgical site but grossly intact. Two-point discrimination slightly decreased around the surgical site but was grossly intact. Light touch also slightly decreased around the surgical site but was grossly intact.

Orthopedic exam:

Range of motion of the ankle and subtalar joints are unaffected. Range of motion of the 1st MPJ status post bunionectomy is non-restrictive with no crepitus but slightly limited secondary to post-operative changes and edema postoperatively. Muscle power is normal everywhere else except the surgical site. The patient is ambulating appropriately for the post-operative date. The patient is not using any assistive devices or scooters. The alignment of the first ray is appropriate and acceptable. There is no clinical finding of the bunion deformity. Hallux is in a good position/rectus position. .

Assessment:

Assessment:

1. Bunion, left foot - M21.612 (Primary)

Provider: [redacted] **DPM**

Date: 10/21/2022

Plan:

Treatment:

1. Bunion, left foot

Notes: 1. The patient was advised that he can wet his foot and dry it after to prevent infection.
2. The patient was advised to continue wearing surgical shoes (until the pin is removed). He can remove the boot at night time.
3. The patient was advised to continue to weight-bear as tolerated.
4. It was explained to the patient that pain and swelling episodes that he experiences at the end of the day are normal post-operative symptoms as the bone is not healed yet properly.
5. A discussion was held with regard to moving his left foot in an up and down motion which would likely help in the healing process.
6. The patient was advised to refrain from activities such as running, jumping, cycling, yoga, and squatting which can put excessive pressure on the feet.
7. Follow up in 2-weeks for pin removal.

Imaging:

Imaging: Fluoroscopy (Performed Date - 10/21/2022)

Three minutes of fluoroscopy was performed to obtain all the angles. * X-ray of the left foot shows there are no changes in the position of the osteotomy. The osteotomy is in good alignment with normal healing, with no definitive changes and alignment in comparison with previous postoperative radiographs. The 1st metatarsal joint space is adequate. Two screws remain intact with no signs of any loosening. For detailed post-operative findings. Please refer to the initial post-operative x-ray.

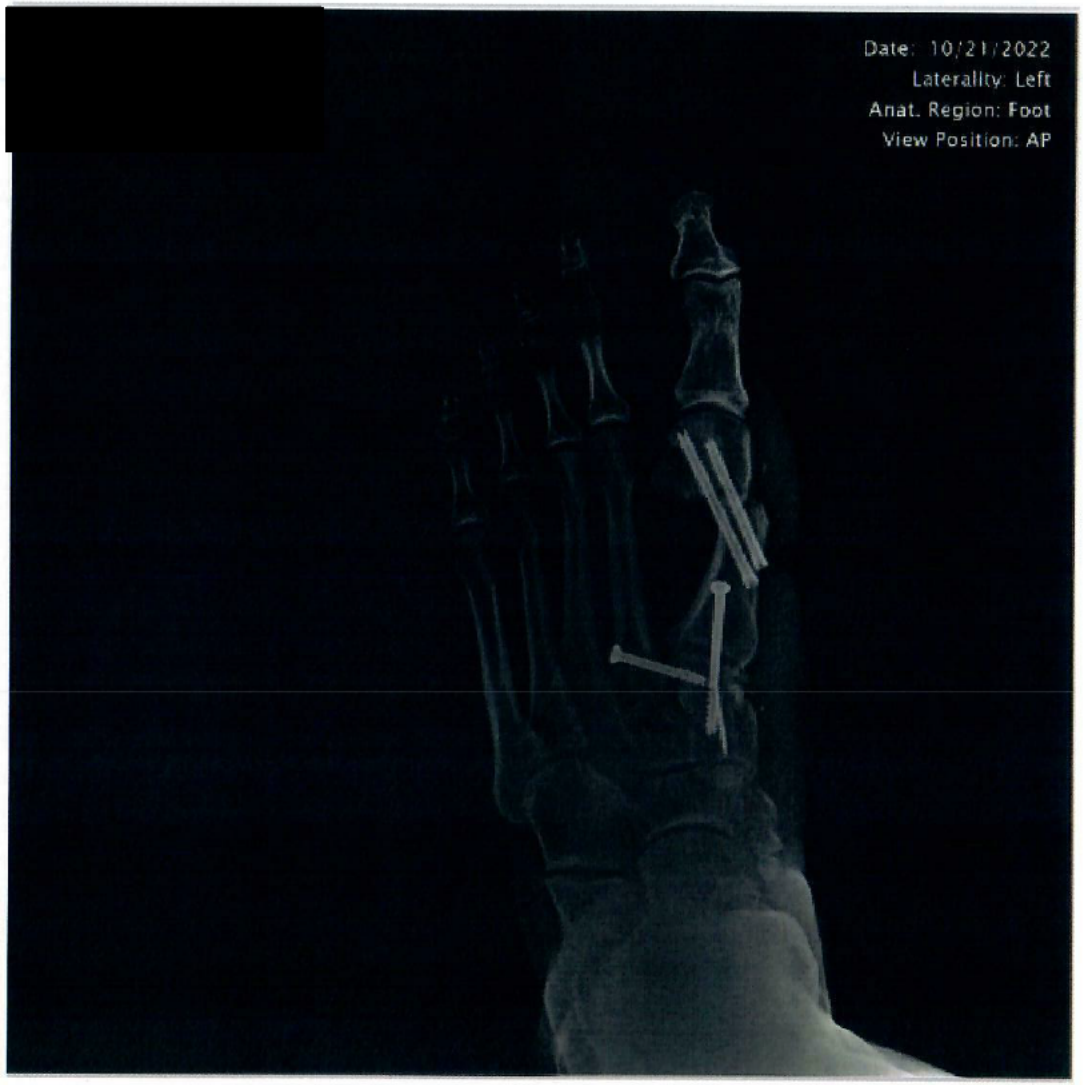
Procedure Codes: 76000 Fluoroscopy Exam Up to an hr, Modifiers: 59

Follow Up: 2 Weeks (Reason: follow-up)

Images:

Electronically signed by [redacted] **DPM**

Provider: [redacted] **DPM** **Date: 10/21/2022**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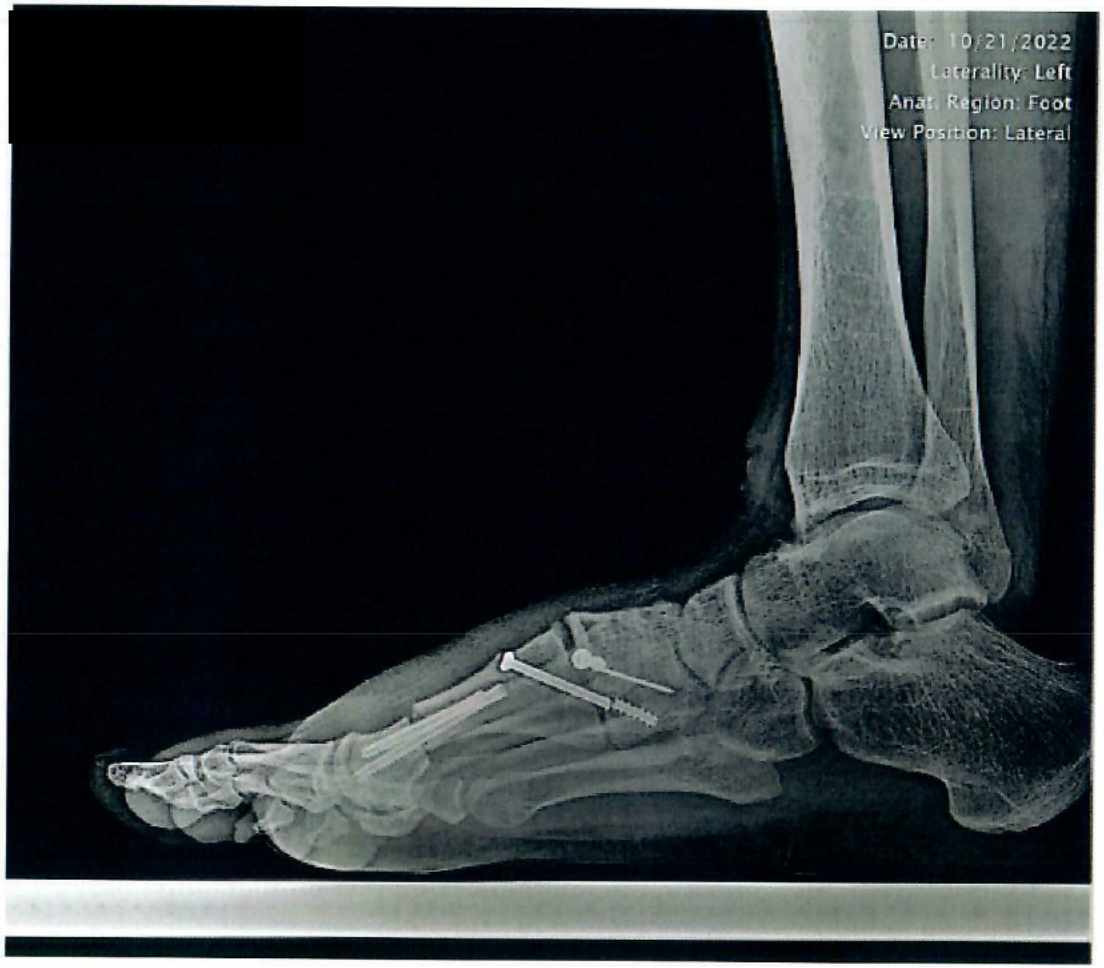
View Position: AP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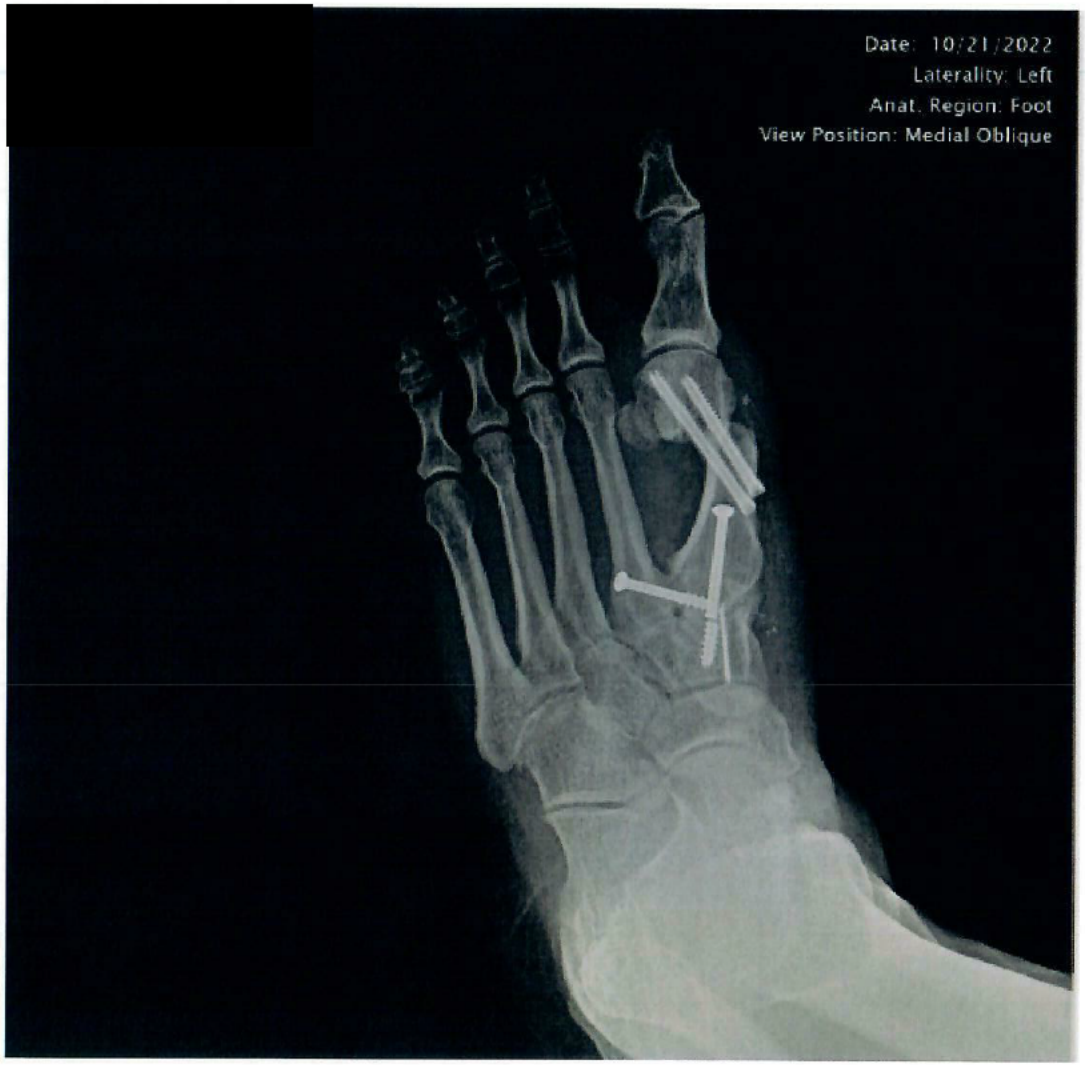
View Position: Lateral


Date: 10/21/2022
Laterality: Left
Anat. Region: Foot
View Position: Medial Oblique

DOS: 11/11/2022

Progess Note

Provider: [redacted] DPM
Date: 11/11/2022

Subjective:

Chief Complaints:
1. f/u bunionectomy EN.

HPI:
History of Present Illness:
The patient returns for follow-up status post left percutaneous bunionectomy on 10/19/2022. He is doing well. He is still wearing his shoe.
Patient denies fevers, chills, wound drainage, or complications.

Medical History: Medical History Verified.

Surgical History: Lis franc surgery 2013, left bunionectomy 10/2022.

Family History:
Patient indicated family medical history with Diabetes Mellitus mentioned Grandmother and Grandfather.

Social History: Smoking Are you a: non smoker. Drug/Alcohol Alcohol no.

Medications: Not-Taking/PRN HYDROcodone-Acetaminophen 10-325 MG Tablet 1 tablet as needed Orally every 6 hrs , Not-Taking/PRN traMADol HCl ER 100 MG Tablet Extended Release 24 Hour 1 tablet Orally Once a day , Not-Taking/PRN traMADol HCl 50 MG Tablet as directed Orally 2

Allergies: N.K.D.A.

Objective:

Physical Examination:
Musculoskeletal:
Foot and ankle Physical examination shows no sign of infection. No open lesion. The range of motion is very good, 90 degrees dorsiflexion and 75 degrees plantar flexion with minimal pain with end range of motion. The swelling is mild..

Assessment:

Assessment:

1. Bunion, left foot - M21.612 (Primary)

Plan:

Treatment:
1. Bunion, left foot
Notes: 1. The patient was advised to continue to weight-bear as tolerated.
2. The patient was advised to continue wearing surgical shoes (until the pin is removed). He can remove the boot at night time.
3. The patient was advised to continue moving his left foot in an up and down motion which would likely help in the healing process.
4. The patient was advised to refrain from activities such as running, jumping, cycling, yoga, and squatting which can put excessive pressure on the feet.
5. Follow up in 2-weeks

Provider: [redacted] DPM **Date: 11/11/2022**

Imaging:

Imaging: Fluoroscopy (Performed Date - 11/11/2022)

Three minutes of fluoroscopy was performed to obtain all the angles. * X-ray of the left foot shows there are no changes in the position of the osteotomy. The osteotomy is in good alignment with normal healing, with no definitive changes and alignment in comparison with previous postoperative radiographs. The 1st metatarsal joint space is adequate. Two screws remain intact with no signs of any loosening. Also, 2 screws are noted from his previous surgery where he had a Lisfranc injury.

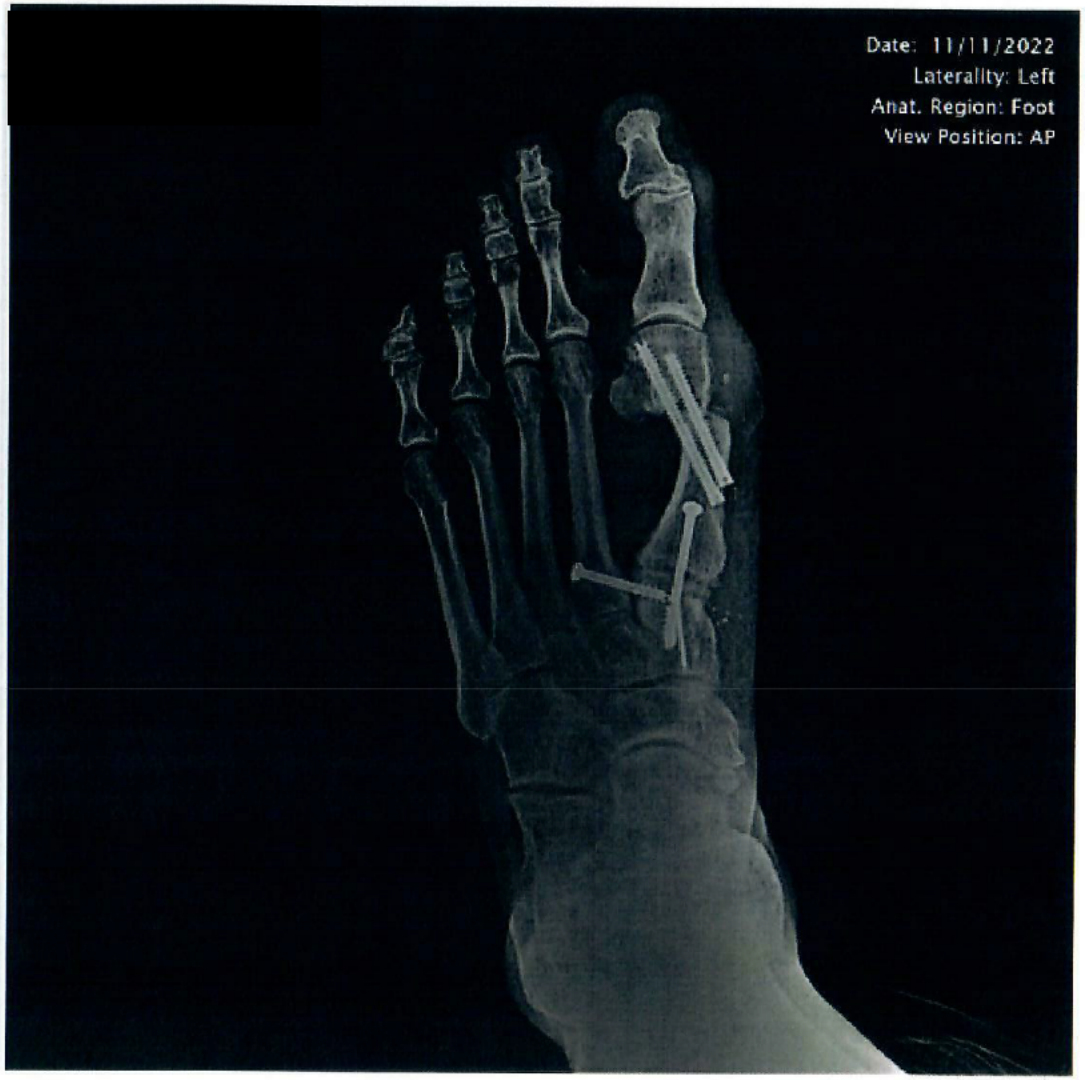
Procedure Codes: 76000 Fluoroscopy Exam Up to an hr, Modifiers: 59

Follow Up: 2 Weeks

Images:

Electronically signed by [redacted] **DPM**

Provider: [redacted] **DPM** **Date: 11/11/2022**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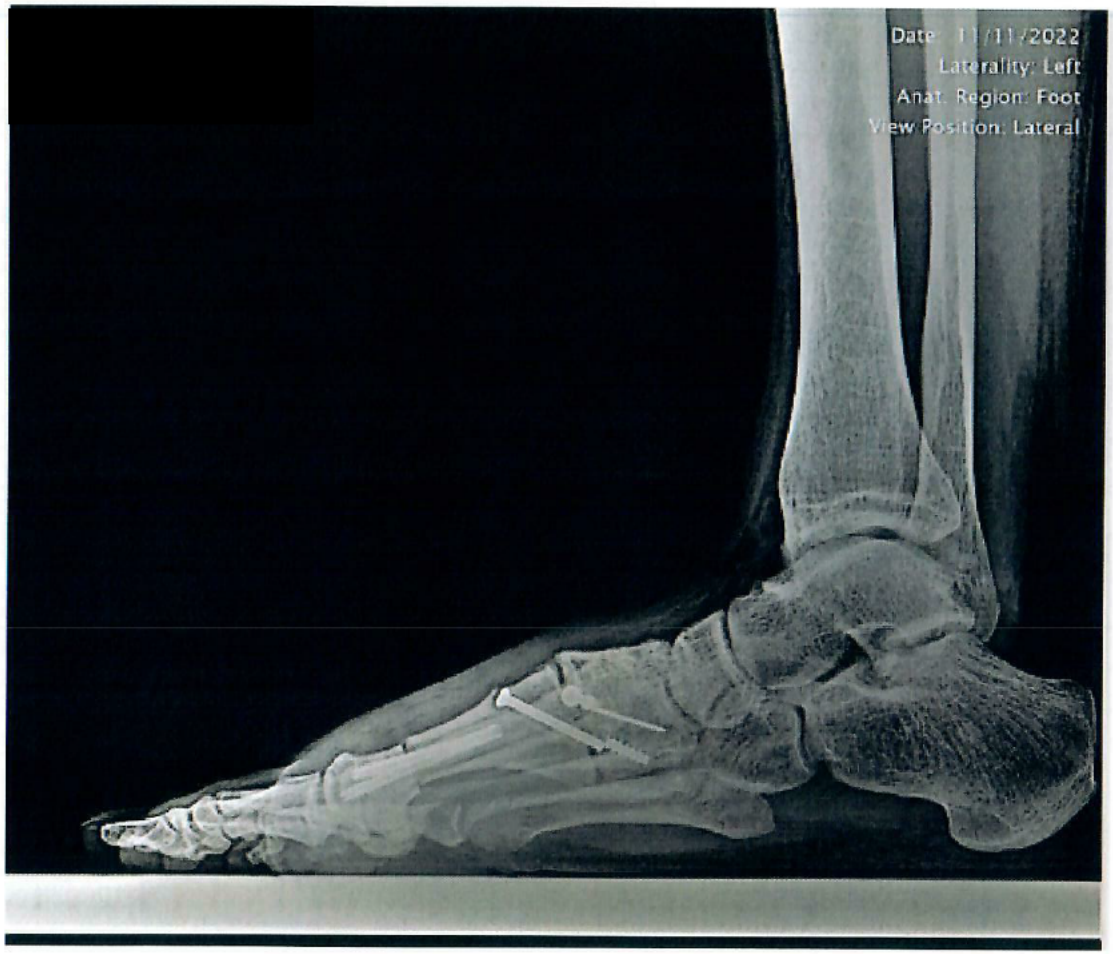
Anat. Region: Foot
View Position: AP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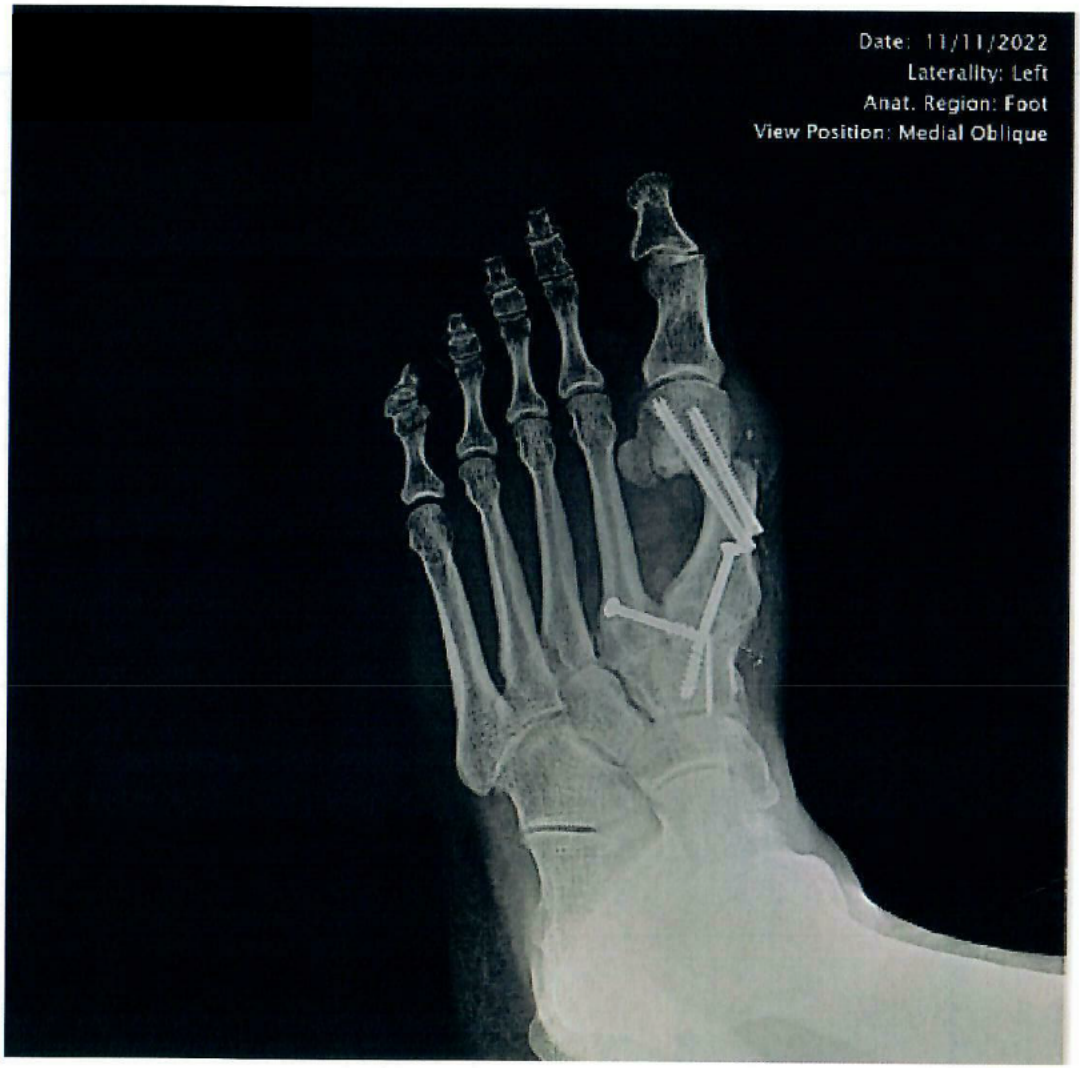
View Position: Lateral


Date: 11/11/2022
Laterality: Left
Anat. Region: Foot
View Position: Medial Oblique

DOS: 12/15/2022

Telephone
Encounter

Answered by [redacted]

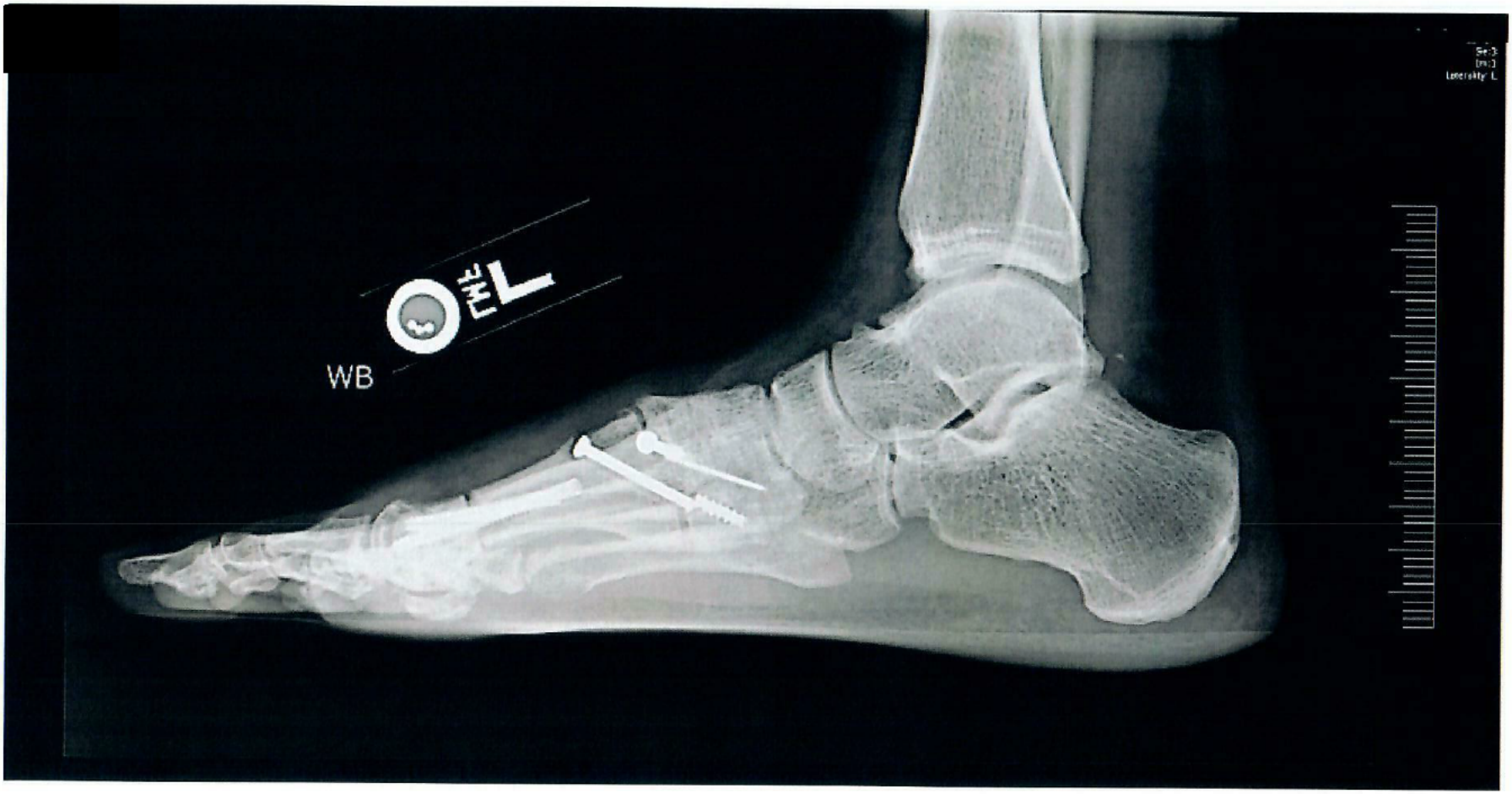
Date: 12/15/2022
Time: 10:25 AM

Reason x-rays

Message Per Dr. K x-ray images look good and everything is healing well. He does not need to get updated X-rays at this time. If he does have any issues he should call us to make an appointment. I called the patient to inform him he did not answer so I left a message.

Provider: [redacted] 12/15/2022

WB
L
LMF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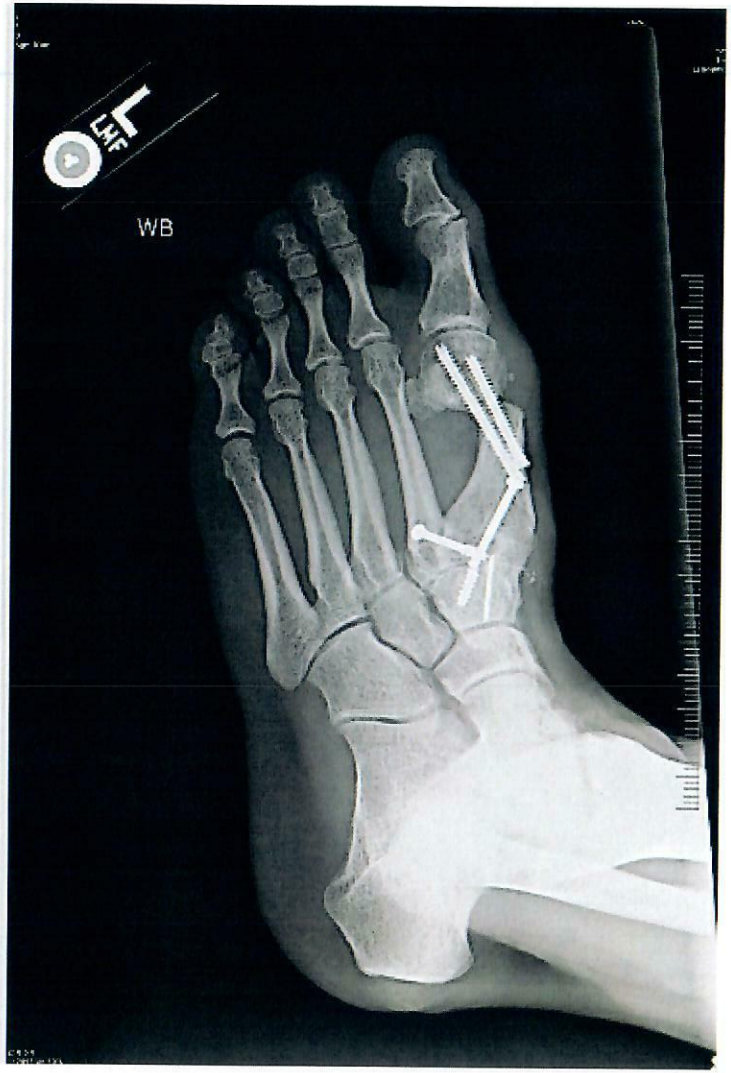
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