Dictation Note
(Blank Template)

January 1, 2050

Name: Joe Sample
Record #: 2813308004
Date:
Pre-Op Diagnosis:
Post-Op Diagnosis:
Procedure:
Surgeon: Dr. Mallet DPM
Assistant:
Anesthesia:
Hemostasis:

Report:

Before surgery
"The patient was brought into the OR suite and placed in the (supine, prone, lateral) position. (MAC, general, spinal) anesthesia was appropriately induced. A pneumatic (ankle/thigh) tourniquet was placed on the (left/right) extremity. Our attention was then directed to the (left/right) site which we noted a (skin tenting, abscess, bunion, deformity, fracture, etc.). Using 20cc of 1:1 mixture of 1% Lidocaine plain and _____cc of 0.5% Marcaine plain, we performed a (Local, Common Peroneal, PT) block in the (MAYO, Ankle block, isolated) fashion. The foot was scrubbed, prepped, and draped in an aseptic manner. An Esmarch bandage was used to exsanguinate

the (left/right) foot. The (ankle/thigh) tourniquet was inflated and set to _____mmHg."

During Surgery
"At this time, attention was directed to the dorsal aspect of the first metatarsal head of the (left/right) foot where a 5cm linear longitudinal incision was made medial to the EHL, following the contour of the deformity. The incision was deepened using blunt dissection. All vital neural and vascular structures were identified. All bleeders were cauterized with Bovie as necessary…"

After Surgery
"The tourniquet was deflated, and it was noted a hyperemic response of the (left/right) lower extremity. A postoperative block consisted of ____cc's of 0.5% Marcaine plain. The incision site was then dressed in_____ (Betadine soaked adaptic, Xeroform, gauze, Kling, Kerlix, steri-strips). A posterior splint, post-op shoe, CAM boot were then applied. The patient will be discharged home with written instructions."

Dictation Note (Sample 1)

January 1, 2050

Surgeon: Dr. Mallet DPM
Assistant: Johnny B Good R3
Pre-op: Left hallux osteomyelitis
Post-op: Left hallux partial amputation
Procedure: Left hallux partial amputation
Anesthesia: MAC
Hemostasis: Left ankle tourniquet, electrocautery
Estimated Blood Loss: 20cc
Materials: 3-0 Vicril, 4-0 Monocril, 4-0 Nylon
Implant: NONE
IV fluids:

Patient presentation:
A 56-year-old MALE with a history of Diabetic Mellitus 2 and peripheral neuropathy presents with a chronic non-healing ulcer of the LEFT hallux with evidence of underlying osteomyelitis.
The procedure of partial Left hallux amputation was explained in detail. We discussed in detail the potential risks and benefits of this surgical intervention. No guarantees were given or implied. The patient wished to proceed with the surgery.

Description of Procedure:
The patient was brought into the surgery room and placed in the operating table in the supine position. The patient was placed for anesthesia under MAC with all bony prominences padded. Next, local sedation of the LEFT foot mayo block with 10cc of 1:1 lidocaine 1% plain and 0.25% Marcaine plain. Ankle tourniquet was placed on the left ankle. The patient's foot was draped and sterilized in an aseptic manner.

Esmarch bandage was utilized on the left foot, the tourniquet was turned on to 250 mmHg. Attention was brought into the LEFT hallux. The site of incision was marked in a fish mouth pattern with a skin marking pen. The incision was made dorsal to the interphalangeal joint using #15 blade down to capsule. All bleeders were cauterized using bovie. The distal interphalangeal joint was disarticulated, removed from the field, and sent as a bone specimen of LEFT hallux to microbiology and pathology. Removal of surrounding devitalized soft tissue was performed. Flexor and extensor tendons where identified and resected at a more proximal level. The surgical site was irrigated with copious amounts of saline. We re-evaluated the foot for all bone and soft tissue to be healthy and viable. The site was closed with simple sutures technique using 3-0 Nylon. Everted skin lines were achieved with no signs of skin tension during closing. Tourniquet was released, the foot showed a hyperemic response to the level of the toes.

The surgical site was dressed using betadine, Adaptic, sterile gauze, kerlix, and Coban. The patient was placed in a post-operative shoe.

Dictation Note (Sample 2)

January 1, 2050

Surgeon:
Assistant:
2nd Assistant:
Pre-operative Diagnosis: Stage 1 Hallux Rigidus
Post-operative Diagnosis: Left 1st metatarsal Youngswick and Cheilectomy
Procedure performed: Decompression osteotomy of left 1st metatarsal head
Anesthesia: General Anesthesia with Mayo block
Hemostasis: 250mmg Hg left ankle tourniquet
Estimated blood loss: Minimal
Prosthetics: Stryker screw set
Injections: 16 cc of 0.5% Marcaine plain
Specimens: None
Complications: None

Description of the Procedure: The patient was brought into the OR suite and placed in the supine position. MAC anesthesia was appropriately induced. The foot was then scrubbed and draped in the usual aseptic manner. A pneumatic ankle tourniquet was placed on the left foot and set to 300 mmHg. Using 16 cc 0.5% Marcaine plain we performed a 1stMTPJ block in the Mayo fashion. A time-out was performed per protocol.

A #10 blade was used to make a dorsal longitudinal skin incision over the 1st metatarsophalangeal joint. Blunt dissection was used through the superficial fascia and surrounding scar tissue of the metatarsal head. The extensor halluces longus and neurovascular structures were identified and retracted for protection. Hemostasis was achieved via Bovie. The1stMTPJ capsule was released with a linear capsulotomy. A McGlamery was used to release adhesion on plantar surface. The medial eminence and cheilectomy of the dorsal osteophyte was performed using a bone saw. An axis guide was inserted on the metatarsal head. The osteotomy was performed using Youngswick technique, the metatarsal head was shifter 2mm laterally and shortened 3mm. C arm fluoroscopy was used for AP and Lateral imagine ensuring metatarsal head positioning. Fixation was accomplished with one 2.5 mm screw perpendicular to the dorsal wing. The 1st metatarsal head was contoured with a rasp. Loose osteophytes were removed with a rongeur.

Patient's surgical site was irrigated with a saline wash. The capsule was closed with a 4-0 vicryl simple interrupted suture. Subcutaneous closed with a 5-0 buried knot suture. The skin was closed with a 5-0 nylon horizontal mattress suture. Tourniquet was deflated and noted a hyperemic response with brisk capillary refill. The incision was then dressed with betadine, Adaptic, 4 x 4 sterile gauze, Kling, and stocking mesh. CAM boot applied on the left foot. The patient was woken without any further complications.

Disposition: Home
Condition: Patient postoperatively stable
Postop Instructions: Able to WB as tolerated in a CAM boot. Keep the foot elevated as much as possible and dressings intact. Start early ROM. Patient to take pain medications as needed. Patient to return to Podiatry clinic for follow up in 1 week.