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.