

Preoperative Assessment

ABFAS is looking for your preoperative clinical and radiographic assessment of the specific condition requiring/leading to the surgical procedure.

Progress Note, Podiatry

* Final Report *

Result type: Progress Note, Podiatry

Result date:

Result status:

Auth (Verified)

Result title:

S0377-LE

Performed by:

Verified by:

Encounter info:

Contributor system:

* Final Report *

DOC01455 (Verified)

CHIEF COMPLAINT/REASON FOR VISIT

Left foot fractures.

HISTORY OF PRESENT ILLNESS

is a who presents to my clinic today with complaints of left foot fractures. He sustained this injury on Patient notes that he was out when he stepped off a curb wrong rolling his foot. He does note that he was drinking at the time. He wore a friend's boot and crutches until he was seen on where radiographs revealed displaced 3rd and 4th metatarsal fractures as well as essentially nondisplaced 2nd metatarsal fracture. He does note today that he has been ambulating on the extremity in the boot. His pain has improved to some extent.

SYSTEMS REVIEW

Denies calf pain, shortness of breath, or chest pain.

ALLERGIES

Acetaminophen and aspirin.

MEDICATIONS

Reviewed per EMR.

PAST MEDICAL/SURGICAL HISTORY

PAST MEDICAL HISTORY: Depression. Generalized anxiety. ADHD.

PAST SURGICAL HISTORY: None.

FAMILY HISTORY

Denies.

SOCIAL HISTORY

Patient is single. He does not currently use tobacco products is a former smoker, noting that he quit about 4 months ago. He consumes on an average 6 drinks per day and typically over 30 drinks per week.

PHYSICAL EXAMINATION

Printed by:

Printed on:

VITAL SIGNS:

PHYSICAL EXAMINATION

GENERAL: Patient alert, oriented, and in no apparent distress.

VASCULAR: Dorsalis pedis and posterior tibial pulses are palpable at 2/4. Capillary refill is within normal limits to all digits of the left foot. Pedal hair growth is present to the digits. No areas of necrosis noted.

DERMATOLOGIC: Skin of normal texture and turgor without signs of atrophy or open lesions. No erythema or edema noted. Toenails appear healthy without signs of discoloration or thickening.

NEUROLOGIC: Gross sensation is intact to all digits on the left foot without signs of peripheral neuropathy.

MUSCULOSKELETAL: There is edema to the left forefoot, midfoot with palpatory tenderness over the 2nd, 3rd, and 4th metatarsal midshaft fractures. There is no sign of fracture blistering or compartment syndrome. His foot compartments are soft and supple. There is no Lisfranc tenderness. Active and passive dorsiflexion and plantar flexion are intact to the level of the ankle as well as to all digits. There is no skin tenting. The skin lines are present. Remainder of forefoot, midfoot, rearfoot, and ankle is nontender to palpation. Ankle joint range of motion is smooth and largely within normal limits. Calf is soft and nontender.

DIAGNOSTICS

Three views of the left foot and ankle exhibit displaced 3rd and 4th metatarsal midshaft fractures as well as essentially nondisplaced 2nd metatarsal midshaft fracture. There is lateral translation and some degree of shortening appreciated to the 3rd and 4th metatarsal fractures. Lisfranc complex is well aligned. No other overt fractures are appreciated.

IMPRESSION/REPORT/PLAN

1. Displaced left 3rd and 4th metatarsal diaphyseal fractures.
2. Nondisplaced 2nd metatarsal diaphyseal fracture secondary to injury.

PLAN: I did review imaging and discussed findings with [REDACTED] today. At times, fractures can be treated conservatively without surgical intervention and at other times require surgical intervention. While his fractures could potentially heal in the current position, they are not in ideal alignment and are also at higher risk for delayed or nonunion, subsequent structural deformities of the foot. As a result, I would recommend surgical open reduction internal fixation of the 3rd and 4th metatarsal fractures. I discussed with them what this would entail. Patient would need to be nonweightbearing for up to 6 weeks postoperatively and with another month of protected weightbearing in a boot after that. We discussed all risks and potential complications of surgery which include but are not limited to superficial or deep infection, bone infection, nonunion, delayed union, or malunion, hardware complications, wound healing complications, temporary or permanent numbness, painful or unsightly scarring, ongoing pain despite surgical intervention, need for repeat surgical intervention, injury to adjacent structures, blood clot formation, pulmonary embolus that could be life-threatening, or complications with anesthesia that could be life-threatening. I did perform a DVT risk assessment today. Patient has no personal or familial history of thrombosis. He will be nonweightbearing postoperatively. We will have him take aspirin 81 mg 2 times a day postoperatively and perform range-of-motion exercises 5 times a day reps of 20 through all major joints. I did discuss signs and symptoms of blood clot formation or pulmonary embolus and what to do if he experiences these. We also discussed time off work. He will plan to be off work for 3 weeks at then strictly seated nonweightbearing work after that. I dispensed a short boot for him today. I also put an order for a Roll-A-Bout scooter as well. We will plan to move forward with surgical intervention on [REDACTED]. This can be performed under monitored anesthesia care in the out-patient surgical setting. Patient will obtain a preoperative history and physical prior to that time. All questions are answered per his satisfaction. Absolutely no guarantees were given or implied in regard to surgical intervention.