through the sinus tarsi and released the cervical ligament and freed up the sinus canal to allow for placement of the stent. We then placed a guide pin into the sinus tarsi subtalar joint and sinus canal. We were able to tent the skin medially and identify the path we wanted to follow. We took intraoperative fluoroscopy and were happy with the location. We then tried to use the trial sizers and found that a #6 implant was most appropriate in her case for adequate correction without being too big and displacing the joint. We then called for a #6 HyProCure stent, followed the guide pin, and placed it as deep as we could until we felt it was solid, holding up the medial column and stabilizing the foot with no further subluxation of the subtalar joint. We removed the guide pin and took intraoperative fluoroscopy. We were happy with the placement of the implant with both the AP view and lateral view.

We then flushed with copious amounts of sterile saline. We began closure with 3-0 Vicryl for deep tissue reapproximation, 4-0 Biosyn for subcutaneous tissue reapproximation, and 4-0 Prolene for skin reapproximation in a simple suture technique. Antibiotic ointment, Adaptic, 4x4s, and Kling wrap were applied to the right foot. We placed on cast padding electrodes for the patient to use her own TENS unit, which she accepts full responsibility for. We then placed on the cooling system over the cast padding with insulation between her skin and the device. We then placed on a posterior splint. General anesthesia was ceased. It was noted that the ankle pneumatic tourniquet had been deflated previously with immediate capillary refill to digits one through five of the right foot. The patient was taken from the operating room tom the recovery room with vital signs stable and vascular status intact. She will be held in recovery for a period of time for monitoring and evaluation. Following adequate stabilization, she will be discharged home with her husband. She will follow up in my office and work in conjunction with another podiatrist locally for suture removal. When I see her in the office, I will take further x-rays and assess her condition, but she is to remain non weight bearing for the time being.

DMG/nb
DD: 2/6/14
DT: 2/6/14

David M. Gent, D.P.M.

PACIFIC SURGERY CENTER
20669 Bond Road NE
Poulsbo, WA 98370
(360) 779-6527