

OPERATION REPORT

CABRINI BRIGHTON

NAME : Mr Natham Raco
72 Vida Street
Aberfeldie VIC 3040

UR NUMBER:

DATE: June 26, 2018

PROCEDURE: scar revision left thigh
PROCEDURE SIDE: Left
Day Surgery

SURGEON: Prof Christopher Coombs

ANAESTHETIST: Dr Mark Langley

ASSISTANT:

PREOP DIAGNOSIS: wide scar left thigh

POSTOP DIAGNOSIS: wide scar left thigh

FINDINGS: wide scar left thigh

PROCEDURE:

Under Ga and LA infiltration the thigh was prepped and draped in a routine fashion. The scar was excised and a medial thigh advancement flap raised and advanced to fill the defect. The skin was closed following haemostasis with 3/0 monocryl. The wound was dressed with mefix. Postoperative analgesia was provided with 0.5% marcain instilled into the wound using the sausage technique.

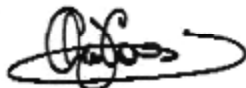
POSTOPERATIVE INSTRUCTIONS:

RPAO
Home
rv as organised
Can shower over dressing and pat dry

ITEM NUMBERS:

45203

CC: DR JEAN LOW, MONTGOMERY STREET CLINIC
318 ASCOT VALE ROAD, MOONEE PONDS, 3039



*Prof Christopher Coombs
Clinical Professor, Uni of Melb
Plastic Hand and Cosmetic Surgery*

OPERATION RECORD

Procedure: gracilis transfer to L arm

Side: Left

Pre-op Dx: arthrogryposis

Post-op Dx: arthrogryposis

Date: 20/12/2012

Surgeon: Prof Christopher Coombs

Assistant: Dr Sara Atkins

Anaesthetist: Dr Billy Browne

Hospital: Royal Children's Hospital

Mr Natham Raco

72 Vida Street

Aberfeldie 3040

GP: Dr Jean Low

URNO: DOB: 06/04/1993

FINDINGS

Arthrogryposis Absent L Bicep

TECHNIQUE

Under GA and LA infiltration the left leg and The L arm and chest were prepped and draped in a routine fashion. The gracilis was harvested as a neurovascular flap. The Obturator nerve was interfascicularly neurolysed and then neurectomised. The vessels to gracilis were divided. Hemostasis was obtained and the leg was closed with a 15g Blake drain. The incisions were closed with 3/0 monocryl.

An incision was made on the L upper arm and thru the axilla and across the chest. The pectoralis minor was reflected as a muscle flap. The 3rd 4th and 5th intercostal nerves were harvested and transposed into the axilla. The terminal branches of the brachial plexus were neurolysed to expose the brachial artery and vein both of which were explored. The upper humerus was exposed and the gracilis fixed to the humerus with a 3mm fastin anchor. The artery was first repaired end to side to the brachial artery and then the veins were anastomosed to a large vein in the axilla. This was done with 9/0 nylon. The artery failed to flow satisfactorily and was therefore redone to a branch of the brachial artery and following this it flowed instantly. Ischaemia time was 150minutes. The 3rd 4th and 5th intercostal nerves were then coapted to the obturator nerve with 9/0 nylon and fibrin glue. The Pec minor was then replaced as a muscle flap over the rib donor sites. The gracilis was then inserted into the radius with a 3.0mm fastin anchor. The skin was closed with 3/0 monocryl and 2 drains were used for the chest and the arm. The wounds were dressed with dermabond and the drains were sutured with m4/0 pronova. The patient was discharged to recovery in a satisfactory condition.

POST-OP ORDERS

RPAO

IDC

Doppler 30 minutely

OPERATION REPORT

CABRINI BRIGHTON

NAME : Mst Natham Rao
72 Vida Street
Aberfeldie VIC 3040

UR NUMBER:

DATE: 7 June, 2011

PROCEDURE: L cubital tunnel release and L elbow release L tricep lengthening
PROCEDURE SIDE: Left
Inpatient

SURGEON: Mr Christopher Coombs
ANAESTHETIST: Dr Robert McDougall
ASSISTANT: Mr Michael Woodfield

PREOP DIAGNOSIS: Arthrogryposis
POSTOP DIAGNOSIS: Arthrogryposis

FINDINGS: L elbow contracture and arthrogryposis

PROCEDURE:

Under GA and LA blocks and tourniquet control the hand was prepped and draped in a routine fashion. The old incision was opened and the cubital tunnel exposed. This required neurolysis of the medial nerve of forearm. The ulnar nerve was then released and transposed anteriorly into a subcutaneous position. The tricep tendon was lengthened with a W-plasty. The tendon was transposed distally to reconstruct the tricep tendon. The medial head of tricep was raised as a muscle flap and transposed radially to fill the defect of the tricep tendon lengthening. The extensor contracture of the elbow was released with division of the posterior capsule of the elbow joint. The triceps was repaired with 2 ethibond. The skin was closed with 4/0 monocryl and dressed with dermabond. Postoperative analgesia was provided with 0.5% marcain instilled into the wound using the sausage technique. The arm was placed in a cast at 90 degrees of elbow flexion. The wound was drained with a 10g blake drain. The patient was discharged to recovery in a satisfactory condition.

POSTOPERATIVE INSTRUCTIONS:

RPAO
Home on Thurs am
Sling
review as organised
hand surgery information sheet

ITEM NUMBERS:

39321 39330 45012 47966 50112

CC: DR JEAN LOW, MONTGOMERY STREET CLINIC
318 ASCOT VALE ROAD, MOONEE PONDS, 3039



*Christopher Coombs
Clinical Associate Professor
Plastic Hand and Cosmetic Surgery*

OPERATION REPORT

LINACRE PRIVATE HOSPITAL

NAME : Mst Natham Raco
P.O. Box 304
Niddrie VIC 3042

DATE: 26 November, 2009

PROCEDURE: Open carpal tunnel release
PROCEDURE SIDE: Right
Day Surgery

SURGEON: Mr Christopher Coombs

ANAESTHETIST: Dr Philip Ragg

ASSISTANT: Dr Tim Gray

PREOP DIAGNOSIS: Recurrent CTS

POSTOP DIAGNOSIS: Recurrent CTS

FINDINGS: CTS L hand

PROCEDURE:

Under Ga and LA infiltration the hand was prepped and draped in a routine fashion. The CTR was performed thru a palmar incision. A flexor tendon synovectomy was performed. The median nerve was released throughout its length. Postoperative analgesia was provided with 0.5% marcain instilled into the wound using the sausage technique.

The wound was closed with 5/0 CCG and dressed with betadine ointment gauze crepe and webril and fibreglass slab.

The patient was discharged to recovery in a satisfactory condition to be reviewed in the office as planned.

The wound was closed with 5/0 CCG and dressed with betadine ointment gauze crepe and webril and fibreglass slab.

The patient was discharged to recovery in a satisfactory condition to be reviewed in the office as planned.

POSTOPERATIVE INSTRUCTIONS:

RPAO
Home
Sling
RV as organised.

ITEM NUMBERS:
39331 46339



*Christopher Coombs
Clinical Associate Professor
Plastic Hand and Cosmetic Surgery*

OPERATION REPORT

LINACRE PRIVATE HOSPITAL

NAME : Mst Nathan Raco
PO Box 304
(Unit 1, 12 Bowes Avenue
Niddrie VIC 3042

UR NUMBER:

DATE: 14 May, 2009

PROCEDURE: Left Open Carpal Tunnel Release
PROCEDURE SIDE: Left
Day Surgery

SURGEON: Mr Christopher Coombs

ANAESTHETIST: Dr Philip Ragg

ASSISTANT: Dr Tim Gray

PREOP DIAGNOSIS: CTS

POSTOP DIAGNOSIS: CTS

FINDINGS: Left CTS in arthrogryposis

PROCEDURE:

Under Ga and LA infiltration the hand was prepped and draped in a routine fashion. The CTR was performed thru a palmar incision. A flexor tendon synovectomy was performed. The median nerve was released throughout its length. Postoperative analgesia was provided with 0.5% marcain instilled into the wound using the sausage technique.

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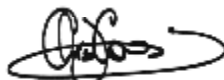
POSTOPERATIVE INSTRUCTIONS:

RPAO
Home
Sling
RV as organised.

ITEM NUMBERS:

46339 39331

CC: DR JEAN LOW, MONTGOMERY STREET CLINIC
318 ASCOT VALE ROAD, MOONEE PONDS, 3039



Christopher Coombs

OPERATION RECORD

Procedure: Release syndactyly R II III IV Webs

Date: 11/02/2000

Surgeon: Prof Christopher Coombs

Assistant:

Anaesthetist: McDougall

Hospital: Royal Childrens Hospital

Mr Natham Raco

72 Vida Street

Aberfeldie 3040

GP: Dr Jean Low

URNO: DOB: 06/04/1993

FINDINGS

Arthrogryposis

TECHNIQUE

Under GA and tourniquet control the hand was prepped and draped in a routine fashion. The incisions were marked and the dorsal flaps raised. The fingers were separated and all neurovascular bundles preserved. The flaps were sutured into position and the tourniquet deflated. Full thickness grafts were harvested from the groin and sutured into position using 5/0 CCG. The groin was closed with 5/0 monocril and the hand was dressed with betadine ointment wet gauze dry gauze and crepe. The hand was then placed in a fibreglass cast and the patient was discharged home on the day following surgery to be reviewed in the office in two weeks time.

POST-OP ORDERS

Routine post anaesthetic orders

Keep hand elevated on IV pole

Circulation observations 1 hourly

Report bleeding, circulation change.

Home with sling.

OPERATION RECORD

Procedure: Syndactyly release L II/III/IV Webs

Post-op Dx: Arthrogryposis

Date: 02/06/1999

Surgeon: Prof Christopher Coombs

Assistant: Bartlett

Anaesthetist:

Hospital:

Mr Natham Raco

72 Vida Street

Aberfeldie 3040

GP: Dr Jean Low

URNO: DOB: 06/04/1993

FINDINGS

Arthrogryposis

TECHNIQUE

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