

**PATIENT NAME:** NATHAM RACO  
**UR No:** 533447  
**SURGEON:** MR DAVID MCCOMBE  
**ASSISTANT:** DR STEPHEN BUTLER  
**ANAESTHETIST:** DR CAROLYN J TIPPETT  
**PREOPERATIVE DIAGNOSIS:** ULNOCARPAL IMPINGEMENT ASSOCIATED WITH ARTHROGRYPOSIS DEFORMITY  
**OPERATION:** RIGHT ECU TO ECRL TENDON TRANSFER, TENOLYSIS OF PREVIOUS GREEN TRANSFER, TENOLYSIS EPL, POSTERIOR INTEROSSEOUS NEURECTOMY  
**DATE OF OPERATION:** 30/09/2020  
**HOSPITAL:** St Vincent's Private Hospital Melbourne

**PREOPERATIVE NOTE:**

Natham is a 27-year-old man with arthrogryposis multiplex congenita with a past history of multiple procedures for both upper limbs including a Green (FCU to ECRB tendon transfer for wrist extension). He had ongoing problems with ulnar deviation deformity producing ulnocarpal impingement and instability of his distal extensor tendons. He was consented for correction of this.

**PROCEDURE:**

Under general anaesthetic following administration of antibiotics, the right hand was scrubbed, prepped and draped.

The previous dorsal midline incision was reopened and extended proximally and distally. The FCU to ECRB tendon transfer was identified. Tenolysis was performed so as to allow correction of the wrist deformity. The EPL tendon transfer was passed radially to the EPL tendon and it was adherent to this and a further tenolysis of the EPL tendon was performed. The excursion of the proximal FCU muscle was poor and it was elected to divide the tendon transfer so as to optimise the wrist range of motion.

The ECRL tendon was identified. This had previously been attached to the distal radius as a capsulodesis procedure. This was freed and the distal portion of this was mobilised as the recipient for the tendon transfer. The ECU tendon was identified distal to the retinaculum and divided. There were slips of the tendon inserting into the carpus as well as fifth metacarpal. The tendon was retracted proximal to the retinaculum passed in the subcutaneous plane and weaved into the ECRL correcting the deformity.

The retinaculum was repaired deep to the tendon transfers and EPL which were both left in the subcutaneous plane. The ECRB stump was then weaved into the tendon transfer for balance. Haemostasis was obtained. The wound was closed with Monocryl suture. Bulky dressing and a splint applied.

**POSTOPERATIVE ORDERS:**

The patient to be discharged Day 1 postoperatively  
Review in the office in one week

DM  
30/9/2020

DICTATED, BUT NOT SEEN BY: MR DAVID MCCOMBE