INTRODUCTION

Welcome to Jefferson Health Medical Education! After receiving your degree in Podiatric Medicine, you have elected to continue your post-graduate education in the Podiatric Medicine and Surgery Residency Program at our hospital.

Beginning a residency can be a stressful situation. We feel that providing this handbook will help to prepare you for your introduction to the hospital and to our attending staff.

This manual should be referred to whenever you are uncertain about hospital protocol or residency requirements. Keep in mind that this is meant to be a guide and interpretation may need clarification from time to time. Your senior residents are available to answer questions and attendings and your Podiatry Coordinator are very accessible. It is your responsibility to read this manual during your orientation week to clarify any questions which you may have.

The residents in our program will receive a comprehensive education. In addition to the required hospital rotations, you will participate in outside lectures, workshops, case reviews and journal clubs. Interaction with your attendings is encouraged. Additional time spent in private offices of these attendings would certainly add to your experience although it is not required. In addition, if an attending physician asks you to accompany them to a facility that is not part of the Jefferson Einstein system, discuss this with the program Director first.

After each rotation your thoughts, questions and suggestions are always welcome as this will only add to the positive experience of the residents to follow.

We look forward to a rewarding residency experience.

Attestation

This is to certify that I_____, a___year resident in the Podiatric Medicine and Surgery Residency Program have read and reviewed the Residency Manual.

Signed_____Date _____

RULES AND REGULATIONS

1. Daily hours start with respect to the rotation that you are on at the time. Check daily with you chief resident or attending to determine what time that you start each day. For podiatric surgical cases, arrive at the hospital or surgical center one hour prior to the start time of the first surgical case.

2. Pagers must stay on 24 hours per day. Batteries are available (free). Check out with your co-resident when out of pager range, when scheduled off or when on vacation.

3. If calling in sick or leaving early in case of emergency, call Dr. Malik. You must also either email or call the program coordinator. If unable to reach Dr. Malik, notify the hospital podiatry office. Consecutive days missed for illness in excess of three (3) will require a note from your primary physician. Sick leave is not available for personal convenience or for the illness of other family members.

4. Personal days off require residents to fill out a PTO.CONF form found on the home page of New Innovations. You are entitled to 20 working days of vacation. Vacation must be applied for in writing/email/text message at least one month in advance. Personal days and Vacation days must receive approval from Dr. Malik.

5. Residents on non-podiatric rotations are excused from podiatric meetings and lectures that interfere with rotation requirements.

6. The program coordinator will track your vacation, sick and Any of time of out training. (LOA)

7. Your dress code should reflect your position as a physician in residence. Hospital issued scrubs and white lab coats are acceptable including your department labeled jacket.

8. Hospital consultations will be assigned to the podiatry resident on podiatry service and treatment discussed with the attending physician covering office hours or the on call attending after hours.

9. Hospital consultations must be done on the day they are called.

10. Resident evaluations will be done by the service chief, or attending through the New Innovations system and reviewed with the resident once completed.

11. All resident physicians are expected to conduct themselves in an ethical and professional manner at all times. Hospital and office personnel, including professional and nonprofessional employees must be treated courteously. Any problems with hospital personnel must be reported to Dr. Malik.

12. Surgical and activity logs must be maintained by each resident reflecting all clinical and didactic encounters. These will be reviewed monthly by the Program Director. These logs are accessed through www.podiatryrr.com. Sample logs and logging requirements are available in your residency handbook.

13. Resident evaluations of their program year will be completed in New Innovations by the resident at the end of each academic year.
14. Operative reports are the responsibility of the resident who is first assistant on each podiatric surgical case. They must be dictated within 24 hours of the case. Sample reports may be found in the resident handbook.
15. All residents must have current hepatitis vaccination prior to starting their program.
16. Contaminated needle or sharps sticks must be reported to Dr. Malik immediately. Incident report will be completed *as* well as follow up with employee health.
17. Consult the current institutional house staff manual for hospital policies not covered in the podiatry residency manual.

Podiatric Medicine and Surgery Residency Schedule 2025-2026

Month	PGY-1 (Tabitha Nwansi)	PGY-2 (Saifudeen Nausrudeen)	PGY-3 (Benedicte Machili-Fah)
July	Podiatry Service	Podiatry Surgery	Podiatry Service
August	Podiatry Service	Podiatry Service	Podiatry Surgery
September	Hospitalist	Podiatry Surgery	Podiatry Service
October	Internal Medicine	Podiatry Service	Podiatry Surgery
November	Infectious Disease	Podiatry Surgery	Podiatry Service
December	General Surgery	Podiatry Service	Podiatry Surgery
January	Vascular Surgery	Podiatry Surgery	Podiatry Service
February	Podiatry Surgery	Podiatry Service	Podiatry Surgery
March	Emergency	Podiatry Surgery	Podiatry Service
April	Anesthesia/ Imaging	Podiatry Service	Podiatry Surgery
May	Podiatry Service	Podiatry Surgery	Rheumatology / PM&R - Gait Lab
June	Podiatry Service	Pathology / Behavior Science	Podiatry Surgery

(PGY3 – Graduation Sept 2nd) **July** – Pathology / Behavior Science // August – Podiatry Service

Podiatry Surgery Location: Jefferson Einstein Montgomery Hospital (EMCM)
Podiatry Service Location: Jefferson Einstein Philadelphia Hospital (AEMC)

Podiatry Surgery Rotation – Weekly Schedule

Day	AM	PM
Monday	Hospital Rounds / Consultations	Didactics – Dr. Malik
Tuesday	Wound Clinic – Dr. Panah	Surgery / OR / Jefferson Einstein Ortho
Wednesday	Clinic	Hospital Rounds / Consultations
Thursday	**Hospital Rounds / Consultations / Surgery (all day)**	
Friday	**Surgery – Drs. Pagano / Panah / Tran (all day)**	

EMCM resident is responsible for EMCM call to the Emergency Department for the entire month (8am-5pm) and will cover orthopedic foot and ankle cases.

EINSTEIN PODIATRY CONTACT LIST

Jefferson EINSTEIN PHILADELPHIA			
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PROGRAM COORDINATOR			
Katrina Straube	Katrina.Straube@jefferson.edu	215-456-8835	215-680-4323

Podiatry Service Daily Resident Schedule

LOCATION: JEFFERSON EINSTEIN PHILADELPHIA / CENTER ONE / EINSTEIN PODIATRY

Monday:	AM	Inpatient / Clinic
	PM	Inpatient / Clinic / Didactics w/Dr. Malik
Tuesday:	AM	Inpatient / Clinic
	PM	Inpatient / Diabetic Clinic
Wednesday:	AM	Center One OR
	PM	Board Review w/ Dr. Malik
Thursday:	AM	Inpatient / Clinic
	PM	Inpatient / Clinic
Friday:	AM	Inpatient / Clinic
	PM	Inpatient

Journal Club

As part of our commitment to academic excellence and continuous learning, our program conducts **monthly Journal Club sessions.** During these meetings, residents and faculty critically review and discuss recent peer-reviewed journal articles relevant to both surgical and medical aspects of podiatric medicine. This forum not only reinforces evidence-based practice and promotes analytical thinking but also serves as a valuable tool in **preparing residents for board examinations.**

DIDACTIC PROGRAM

There are multiple parts to the didactic program prepared for you atAEMC.

1. Monday Didactic program administered by Dr. Malik
    - ACADEMICS [McGlamry's Review 4th edition]

2. Wednesday Evening board review w/Dr. Malik.

3. Journal Club once a month with residents and faculty members

4. Conferences presented by the Temple College of Podiatric Medicine, Goldfarb

5. Cadaver Lab/Bone Saw Labs will be set up by monthly during the academic year. Dates vary.

6. Institutional curriculum lectures are provided by Jefferson Einstein every third Wednesday for all residents, and attendance is mandatory.

7. Conferences on non-podiatric rotations are per rotation chief guidelines.

8. Development of a poster for the research competition held annually at Einstein is encouraged. Attendings are available for research guidance and collaboration.

SAMPLE DICTATIONS

Detailed Description of Procedures

Akin

Attention was then directed towards the base of the proximal phalanx. Utilizing the sagittal bone saw, a medial based wedge was removed from the base of the proximal phalanx. The osteotomy was closed using a Zimmer 8 mm staple which was inserted according to manufacture guidelines. Appropriate correction was confirmed intraoperatively using C arm.

Hallux and Toe amp

Attention was then directed to the great toe of the patient's left foot where a racquet type incision was made extending proximally, and looping around the hallux of the left foot using a 15 blade. No purulence was noted at the incision site. The incision was carried deep down to the level of the first metatarsal phalangeal joint where the hallux was disarticulated at the joint level. Once disarticulated, the hallux was removed from the operative field and sent for pathologic analysis. The first metatarsal head was inspected and there was no clinical evidence of osteomyelitis and no bony defects. Attention was then directed to the second toe on the patient's left foot, a circumferential incision was made looping around the second toe using a 15 blade. Again no purulence was noted at the incision site. The incision was carried deep down to the level of the second tarsal phalangeal joint where the second toe was disarticulated at the joint level. The second toe of the left foot was also sent for pathological analysis. The second metatarsal head was inspected and there was no evidence of osteomyelitis and no bony defects appreciated. The incision sites were connected into one large wound for better closure. The operative site was then irrigated with copious amounts of sterile saline. Skin closure was then performed utilizing 3-0 nylon in simple suture technique. Clean sterile dressings were supplied to the surgical site consisting of Xeroform, Betadine soaked 4 x 4 gauze, cleaned 4 x 4 gauze, Kerlix, and Ace bandage.

Ankle fracture

Patient was placed supine on the operating table with all bony prominence as well padded. Following intubation a well-padded tourniquet was placed on the right proximal thigh and the lower extremity was prepped in sterile fashion.

A time-out was performed to confirm the identity of patient, the operative site, the operative procedure, and the receipt of IV antibiotics within 1 hour prior to making skin incision.

Operative extremity was exsanguinated and the tourniquet was inflated to 350 mmHg.

All appropriate bony and soft tissue landmarks were identified. A longitudinal skin incision was made over the lateral malleolus. Dissection was carried sharply through the skin and subcutaneous tissues. Thick soft tissue flaps were developed to be dissected directly down onto the lateral malleolus. Care was taken to protect the peroneal tendon posteriorly. Fracture was identified and found to be a spiral fracture that was shortened and externally rotated. Fracture was debrided with a curette and rongeur. Fracture was irrigated with normal saline.

We next performed open reduction internal fixation of the right ankle lateral malleolus fracture. Using bony reduction forceps the ankle was manipulated and the fracture was reduced to anatomic alignment. Alignment was confirmed under fluoroscopic imaging. A 3.5 mm cortical lag screw was placed from anterior to posterior using lag technique. This gave excellent initial fixation. A 7 hole Zimmer one third tubular plate was then contoured and applied the lateral aspect of the fibula. Plate was secured with 3, 3.5 mm, bicortical cortical screws proximally, and 1, 4.0 mm, unicortical cancellous screw and 1 locking screw distally. All screws had excellent fixation. Final fluoroscopic images were obtained to confirm that the fracture was anatomically

aligned with hardware in good position. A cotton test was performed to assess the syndesmosis, which was stable.

Wound was irrigated with normal saline. Deep layer was closed with 0 Vicryl. Subcutaneous tissues were closed with 2-0 Vicryl. Skin incision was closed with 4-0 Monocryl. A sterile aquacel dressing and a well-padded posterior splint with the ankle in neutral dorsiflexion were applied.

Tourniquet was deflated.

All instrument and sponge counts were correct.

Patient was awoken from anesthesia and taken to the PACU in stable condition.

Ankle Arthroscopy

Patient taken to the OR and prepped and draped in usual sterile manner. Attention is drawn to left lower extremity after elevation it was exsanguinated by mean means of an Esmarch bandage and the thigh tourniquet was inflated to 250 mmHg. Attention was drawn to the left ankle where an anterior lateral anterior medial incision was made to 3 portals were entry of the arthroscope. There 2.7 mm arthroscope was inserted into the lateral portal for visualization of the joint. Inspection of the ankle joint revealed hemorrhagic and hypertrophic synovium with excessive formation in the lateral gutter causing impingement syndrome further evaluation revealed cartilaginous softening at the medial talar dome. Synovial shaving was performed with a full-radius shaver as well as a chondroplasty was performed with the abrader shaver. Good motion was noted and visualized with no impingement in the ankle joint. All instrumentation was removed and the incisions were closed with 3-0 nylon. Attention was drawn to the lateral ankle where incision was made overlying the distal fibula incision was deepened all planes of bleeders were identified and coagulated properly. Dissection was carried down to the distal fibula and it was noted complete laxity due to missed functioning of the ATFL from tearing. An Arthrex ankle was inserted into the distal fibula and the ATFL was repaired primarily. Deep tissue was reapproximated and sutured utilizing 2-0 Vicryl in a simple interrupted manner subcutaneous tissues reapproximated and sutured utilizing 3-0 Vicryl in a running locked manner. Skin edges reapproximated and sutured utilizing 2-0 nylon in a running locked manner. 1 cc of dexamethasone phosphate 4 mg/cc was injected into the left ankle. A dry sterile dressing was applied to the left foot as well as a short leg fiberglass cast. Tourniquet was deflated total tourniquet time was 46 minutes. Normal color temperature vascularity was noted to return the digits of the left foot. Patient appeared to tolerate the anesthesia and procedure well left the OR with all vital signs stable in apparent satisfactory condition.

Arthroplasty 5th toe

The foot was lowered into the operative field and eschmarch was used for exsanguination and the ankle tourniquet was inflated. Sterile stockinette was reflected and a 15 blade was used to make a dorsal incision centered over the PIPJ of the right 5th digit. The incision was deepened in the same plane until the PIPJ was exposed. All neurovascular structures were identified and preserved. A transverse incision was made through the PIPJ capsule and the head of the proximal phalanx and base of middle phalanx were freed of all soft tissue. A bone cutter was used to remove the head of the proximal phalanx and a prominence on the dorsolateral aspect of the middle phalanx. The incision site was copiously flushed with sterile saline solution and 4-0 nylon was used to reapproximate the skin in running interlocking technique. a small amount of decadron was infiltrated locally. The wounds are dressed in Adaptic 4 x 4 gauze DSD coban and the tourniquet was deflated. A pink and warm state was seen return of the foot and toes. Patient was then transferred to the PACU in stable condition. The patient tolerate the procedure well and anesthesia well with no complications

Arthroplasty 2nd toe

Attention was then directed at the second toe on the dorsal lateral aspect of the proximal interphalangeal joint. Using a #15 blade, a linear incision was directly dorsal to the proximal interphalangeal joint. The incision was deepened using sharp and blunt dissection. All neurovascular structures were identified and preserved. All bleeding vessels were cauterized as necessary with Bovie. A transverse incision was made to the proximal interphalangeal joint capsule and the head of the proximal phalanx was freed of all soft tissue. A bone cutter was used to remove the head of the proximal phalanx. The incision site was copiously flushed with sterile saline solution. The extensor tendon was reapproximated using Vicryl suture. Skin was reapproximated using 4-0 nylon suture in simple suture technique.

Arthrosurface total 1st MTPJ implant

Attention was then directed on the dorsomedial aspect of the first metatarsophalangeal joint where a 6 cm linear incision was placed directly over the first metatarsophalangeal joint just parallel and medial to the course the extensor hallucis longus tendon. The extensor tendon was retracted and protected out of the surgical field. The incision was deepened through subcutaneous tissue. All bleeding vessels were identified, cut, clamped, and cauterized as necessary. The incision was deepened to the level of the capsule and the periosteum of the first metatarsophalangeal joint. All the neurovascular structures were identified and retracted from the site to be preserved. Using sharp and dull dissection, the periosteal and capsular attachments were mobilized from the head of the first metatarsal and base of the proximal phalanx. Intraoperatively the metatarsal head was noted to be denuded of cartilage, extensive eburnation was noted to the head of the first metatarsal, and significant dorsal spurring was appreciated inhibiting range of motion. The Arthrosurface implant guidepin was advanced into the center of the first metatarsal head making sure the guidepin was perpendicular to the metatarsal. The desired position was confirmed using C arm intraoperatively. The Arthrosurface step drill was used to prepare the screw hole prior to fixation. A reamer was used to remove all the damaged cartilage from the first metatarsal head and to create a socket for the implant. A second reamer was then used to create a dorsal socket. The trial implant was inserted to assess proper fit and to assess first metatarsal phalangeal joint range of motion. At this time it was decided the patient would benefit from a total implant. The base of the proximal phalanx was cleaned of all dorsal osteophytes using rongeur and a proximally one third of the base of the proximal phalanx was resected with use of sagittal saw. Guidepin was inserted into the proximal phalanx. Proper positioning was confirmed using C-arm intraoperatively. Using the appropriate Arthrosurface reamer, the base of the proximal phalanx was prepared for implant. Using a sagittal saw and rongeur all osteophytes and bony edges were removed. The metatarsal implant was then inserted and secured using a mallet followed by the proximal phalanx implant. Position of the total implant was inspected and noted to be flush with all the remaining bone and cartilage surfaces. Range of motion was again assessed intraoperatively and noted to be close to the desired 90° dorsiflexion. Proper placement of the implant was confirmed with C arm intraoperatively.

The incision site was copiously flushed with sterile saline solution. Complex wound closure was begun with capsuloraphy of the first metatarsal phalangeal capsule using 2-0 Vicryl. Closure of the capsule was continued using 2-0 Vicryl. 3-0 Vicryl was then used to suture close the subcuticular layer and lastly skin closure was performed using 4-0 nylon suture in running interlocking technique. Clean sterile dressings were applied to the patient's foot consisting of Xeroform, 4 x 4 gauze, Kling, and Ace bandage. The ankle tourniquet was deflated at 93 minutes, immediate hyperemia was noted to the entire left extremity upon deflation of the cuff. The patient was transferred to the recovery room in stable condition. All instrument and sponge count was correct.

BioPro hemi implant

Attention was drawn to the first MPJ where a dorsal incision was made overlying the joint. The incision was deepened in all planes of bleeders were identified and coagulated properly. Dissection was carried out the joint

capsule where a lenticular capsulotomy was performed. Capsular tissue was dissected free from the osseous attachments and a dorsal exostosis was noted surrounding the first metatarsal head. This was removed in toto from the surgical site utilizing a sagittal saw and remodeled with a sagittal saw and rongeur. Attention was drawn to the base of the proximal phalanx, the base of the proximal phalanx was freed from all soft tissue attachments. Notable exostosis was prominent on the dorsal aspect of the base of the proximal phalanx. Using sagittal saw and rongeur all dorsal exostoses on the base of the proximal phalanx were resected. Using sagittal saw one third of the base of the proximal phalanx was removed. The long flexor tendon was noted to be intact plantarly. The base of the proximal phalanx was prepared for implant according to bio pro manufacturer's guidelines. Utilizing proper technique a bio pro medium implant was noted to fit and the sizer revealed excellent range of motion at the joint. A medium Portis bio pro hemi-implant was then inserted through proper technique into the proximal phalanx. The surgical site was copiously flushed with sterile saline solution. The implant was noted to ride freely over the metatarsal head and dorsally. Deep tissue was reapproximated and sutured utilizing 2-0 Vicryl in a simple interrupted manner. Subcutaneous tissues reapproximated and sutured utilizing 3-0 Vicryl in a running locked manner. Skin edges were reapproximated utilizing 5-0 Monocryl in a subcuticular manner. The wound was Steri-Stripped closed and dry sterile dressings applied to the right foot consisting of Adaptic, 4 x 4 gauze, Kling, web roll, and Ace bandage. The ankle tourniquet was deflated at 34 minutes, immediate hyperemia was noted to the entire right lower extremity upon deflation of the cuff. The patient tolerated the procedure and anesthesia well without complication. The patient was transferred to PACU in stable condition. All sponge and instrument count was correct.

Bunionectomy

Attention was then directed on the dorsomedial aspect of the first metatarsophalangeal joint where a linear incision was placed directly over the first metatarsophalangeal joint parallel and medial to the course the extensor hallucis longus tendon. The incision was deepened through subcutaneous tissue. All bleeding vessels were identified, cut, clamped, and cauterized. The incision was deepened to the level of the capsule and the periosteum of the first metatarsophalangeal joint. All vital tendons and neurovascular structures were identified and retracted from the site to be preserved. Using sharp and dull dissection, the periosteal and capsular attachments were mobilized from the head of the first metatarsal. The conjoined tendon was identified on the lateral plantar aspect of the base of the proximal phalanx and transversely resected from its insertion. A capsulotomy was also performed at the level of the first metatarsophalangeal joint. Dorsal medial prominence of the metatarsal head was adequately exposed using sharp dissection and resected with the use of a sagittal saw. A guidewire was placed in the center of the metatarsal head, using sagittal saw a chevron osteotomy was created and shifted laterally to correct the elevated intermetatarsal angle. Two 3.0 cannulated screws were placed to fixate the osteotomy site. The osteotomy site was found to be fixated and stable and there was no prominence noted from the screws.

Bunionette surgery

Attention was drawn to the right fifth toe to address the bunionette deformity. A long linear incision was created using a No. 10 blade. The incision was deepened through skin and subcutaneous tissue with #15 blade and blunt dissection. Care was taken to preserve all tendons and neurovascular structures. The bovie was used for hemostasis as needed. The periosteum was freed from the metatarsal with use of the No. 15 blade. A closing base wedge osteotomy was performed utilizing a sagittal saw and the base of the fifth metatarsal. Lateral cortex was left intact, the wedge of bone was removed, and the bone was closed down to straighten and correct the bunionette deformity of the fifth toe. The fixation was maintained with k-wire and secured with a Synthes 2.4 cannulated screw. The lateral eminence was removed with sagittal saw. Position and good fixation were confirmed with C-arm intraoperatively. The surgical site was copiously flushed with sterile saline solution. The surgical site was closed in layers beginning with closure of the MPJ capsule with 2-0 vicryl. Subcutaneous closure was performed with 3-0 vicryl and lastly the skin was reapproximated with 5-0 Monocryl suture in

subcuticular technique.

Cartiva

Attention was then directed on the dorsomedial aspect of the first left metatarsophalangeal joint where a 6 cm linear incision was placed directly over the first left metatarsophalangeal joint parallel and medial to the course the extensor hallucis longus tendon to the left great toe. The incision was deepened through subcutaneous tissue. All bleeders were identified, cut, clamped, and cauterized. The incision was deepened to the level of the capsule and the periosteum of the first left metatarsophalangeal joint. All the tenderness neurovascular structures were identified and retracted from the site to be preserved. Using sharp and dull dissection, the periosteal and capsular attachments were mobilized from the head of the first left metatarsal. The conjoined tendon was identified on the lateral plantar aspect of the base of the proximal phalanx of the left great toe and transversely resected from its insertion. Intraoperatively the arthritic changes of the first metatarsophalangeal joint were observed with defect also noted to the head of the first metatarsal. Both the dorsal and dorsal medial prominences of the first left metatarsal head was adequately exposed using sharp dissection and resected with the use of a sagittal saw. The dorsal osteophyte on the lip of the proximal phalanx were removed using rongeur. The head of the metatarsal and base of the proximal phalanx were prepared for implant. A guide pin was placed perpendicular to the central aspect of the first metatarsal head, correct alignment was confirmed using C arm intraoperatively. The guidepin was advanced into the center of the defect until it was securely seated. The cannulated drill bit was used to create a space in the first metatarsal head for the implant. All debris was flushed out of the implant site. The Cartiva implant was introduced using the introducer tube until it sat flush within the implant site created, and left approximately 3 mm proud to abut the base of the proximal phalanx. Range of motion was confirmed intraoperatively against the implant, no restriction or limitation of the joint was noted. All bone debris was noted to be clear from the joint and the surgical site.

Integra Digifuse toe implant

The patient was brought to the operating room and placed in the operating table in supine position. The patient was given 2 g IV Ancef prophylactically. After adequate sedation was achieved by the anesthesia team, 6 cc 0.5% Marcaine was administered in digital block fashion. A left ankle tourniquet was applied to the left ankle and set at 250 mmHg but not inflated. The left foot was prepped, scrubbed, and draped in normal sterile fashion. Time-out was called to identify the patient's identity and correct surgical site. The left ankle tourniquet was then inflated.

Attention was directed at the left second toe. An elliptical incision was created directly over the PIPJ. The incision was deepened in the same plane until the PIPJ was exposed. All neurovascular structures were identified and preserved. A transverse incision was made through the PIPJ capsule and the head of the proximal phalanx and base of middle phalanx were freed of all soft tissue. A bone cutter was used to remove the head of the proximal phalanx and a prominence on the dorsolateral aspect of the middle phalanx. The base of the middle phalanx was prepared for digit use implant using the Integra broach. The digifuse implant was inserted into the proximal phalanx according to manufacturer's guidelines. A K wire was introduced into and through the shaft of the middle phalanx. Proper position down the midshaft was confirmed intraoperatively using C arm. The digifuse implant was inserted into the K wire and the middle phalanx. The bones were noted to be completely reapproximated, arthrodesis having been achieved. The second toe was noted to be sitting in good alignment. The K wire was removed and proper positioning of the implant was confirmed using C arm.

The incision site was copiously flushed with sterile saline solution. 4-0 Vicryl was used to reapproximate the extensor tendon on the second toe, and skin closure was then achieved at the surgical site using 4-0 nylon in running interlocking technique. 0.3 cc Decadron was administered around the osteotomy site for postop pain

control. Clean sterile dressings were applied to the patient's foot consisting of Adaptic, 4 x 4 gauze, Kling and Coban. At this time the ankle tourniquet was deflated at 35 minutes, immediate hyperemia was noted to the entire left lower extremity upon deflation of the cuff. Fixation was verified using C arm. The patient's left lower extremity was placed into a surgical shoe. The patient was transferred to the recovery room in stable position. All instrument and sponge count was correct.

EPF

Attention was drawn to the medial aspect of left ankle. A small horizontal skin incision was created at the medial side of the heel at the insertion of the medial band of the plantar fascia at the calcaneal tuberosity. The obturator was introduced through the skin incision and passed under the plantar fascia until it was palpable against the skin on the lateral heel. Another horizontal skin incision was created at the lateral side of the heel at the insertion of the lateral band of the plantar fascia allowing the obturator to pass through the lateral portal. The obturator was removed and the slotted cannula was left under the plantar fascia. Multiple cotton swabs were used to remove the fluid and debris from the visual field. The endoscope was introduced into the medial portal and the plantar fascia was clearly visualized. Tension was applied on the plantar fascia by dorsiflexing the foot and ankle. The hook knife followed by the triangle knife was inserted through the medial portal and the medial band of the plantar fascia was released. Care was taken to ensure the lateral band of the plantar fascia remained intact. The surgical area was irrigated with copious amount of sterile saline. The skin of medial portal and lateral portal was reapproximated with 4-0 Nylon suture. The incision was dressed with Xeroform,4x4 gauze, web roll, Kling, and Ace bandage. A combination of 2 cc Dexamethazone and 2 cc 0.5% Marcaine plain was injected into the surgical site for post operative pain and inflammation control. The tourniquet was deflated at 27 minutes, immediate hyperemia was noted to return to the entire left lower extremity upon deflation of the cuff. The patient tolerated the procedure and anesthesia well, without complication. The patient was transferred to PACU in stable condition. All sponge and instrument count was correct.

Plantar Fibroma

Attention was then directed at the plantar aspect of the foot overlying the plantar fibromas located along the medial band of the plantar fascia. Using a #15 blade, A long curvilinear incision was created around the fibroma following the relaxed skin tension lines. The incision was created and deepened with blunt and sharp dissection to the layer of fat. Using tenotomy scissors, the incision was deepened and the fibroma was demarcated. Care was taken to preserve all neurovascular structures. Bleeding vessels were cauterized as necessary. Healthy fascia and surrounding muscle tissue was separated and clamped from the fibroma with the use of a straight hemostat. The mass was carefully resected from the surrounding healthy fascia and tissue using tenotomy scissors. The fibroma was passed off the field as specimen for pathological analysis. The surgical site was inspected, all soft tissue masses were noted to be removed. Healthy fascia was ensured intact and functional. The surgical site was copiously flushed with sterile saline solution. Closure was begun with subcuticular closure with 3-0 Vicryl suture. Skin was reapproximated with 2-0 Nylon suture in horizontal suture technique. Clean dressings were applied to the patient's foot consisting of Xeroform, Betadine soaked 4 x 4 gauze, 4 x 4 gauze, Kling, Kerlix, and Ace bandage. The tourniquet was deflated at 18 minutes, immediate hyperemia was noted to return to the entire lower extremity upon deflation of the cuff. The patient tolerated the procedure and anesthesia well. The patient was transferred to PACU in stable condition. All sponge and instrument count was correct.

5th metatarsal fracture

The patient was brought to the operating room and placed in the operating table in supine position. The patient was given 2 g IV Ancef prophylactically. After adequate sedation was achieved by the anesthesia team, 30 cc

1:1 mix 0.5% Marcaine plain and 2% Lidocaine plain was administered in ankle block fashion. A left ankle tourniquet was applied to the left ankle and set at 250 mmHg but not inflated. The left foot was prepped, scrubbed, and draped in normal sterile fashion. Time-out was called to identify the patient's identity and correct surgical site. The left ankle tourniquet was then inflated.

Attention was then directed at the base of the left fifth metatarsal. A small linear incision was created directly overlying the fifth metatarsal fracture using a #15 blade. The incision was deepened to bone with sharp and blunt dissection using tenotomy scissors. Care was taken to preserve all tendons and neurovascular structures. The Bovie was used for hemostasis as needed. C-arm was used intraoperatively to fully appreciate the fracture line which was clearly visible at the base of the fifth metatarsal. A K wire was thrown from the proximal base fifth metatarsal fracture across the fracture site distally. Proper positioning was confirmed using C arm. Using proper AO technique, 4.5 screw was thrown from the proximal fifth metatarsal base down the shaft and the fracture site was fixated rigidly. All this was done under fluoroscopy. Excellent correction of the fracture and positioning was confirmed. The surgical site was copiously flushed with sterile saline solution. Subcutaneous closure was achieved with Vicryl suture and skin was reapproximated using Nylon suture in running interlocking technique. The surgical site was dressed with clean sterile dressings consisting of Xeroform, 4 x 4 gauze, Kling, and Ace bandage. The left ankle tourniquet was deflated at 72 minutes, immediate hyperemia was noted to return to the entire left lower extremity upon deflation of the cuff. The patient tolerated the procedure and anesthesia well, without complication. The patient was transferred to PACU in stable condition. All sponge and instrument count was correct.

5th toe amputation

Attention was directed at the right lateral foot over the large abscess. Using a #15 blade, a raquet shaped incision was created deep to bone around the fifth digit and extending proximal to the mid fifth metatarsal shaft. Care was taken to preserve all vital neurovascular structures. All bleeding vessels were cauterized as necessary. Using a sagittal saw, the fifth metatarsal head was resected just proximal to the surgical neck which was the most proximal bone infected per MRI imaging. The fifth metarsal was passed of the field as specimen for pathological analysis. All infected bone and tissue was passed off the field as specimen for pathological analysis. Another more proximal small portion of the base of the fifth metatarsal was excised using a sagittal saw and sent as a clean margin. The surgical site was inspected all remaining tissue was viable. Cultures were taken andte wound was copiously flushed with sterile saline solution. The surgical site was again inspected and noted to be clean of any remaining abscess, infected soft tissue, or infected bone. Clean sterile dressings were applied to the patient's left foot consisting of Betadine soaked Adaptic, Betadine soaked 4 x 4 gauze, 4x4 guaze, Kerlix, and Ace bandage. The patient tolerated the procedure and anesthesia well, without complication. The patient was transferred to PACU in stable condition. All sponge and instrument count was correct. Please note that this is a staged procedure and will likely require further debridements in the future as well as skin grafting to help expedite the healing of the wound. Today, our goal was to erradicate the infected tissues and bone and prevent limb loss and death.

Arthrosurface hemi-implant

Attention was then directed on the dorsomedial aspect of the first right metatarsophalangeal joint where a 6 cm linear incision was placed directly over the first right metatarsophalangeal joint parallel and medial to the course the extensor hallucis longus tendon to the right great toe. The incision was deepened through subcutaneous tissue. All bleeders were identified, cut, clamped, and cauterized. The incision was deepened to the level of the capsule and the periosteum of the first right metatarsophalangeal joint. All the neurovascular structures were identified and retracted from the site to be preserved. Using sharp and dull dissection, the periosteal and capsular attachments were mobilized from the head of the first right metatarsal. Intraoperatively the metatarsal head was noted to be denuded of cartilage. The base of the proximal phalanx was inspected and

the cartilage was noted to be intact. At this time it was decided a hemi-implant would be best suited for the patient. The guidepin was advanced into the center of the first metatarsal head making sure the guidepin was perpendicular to the metatarsal. The desired position was confirmed using C arm intraoperatively. The Arthrosurface step drill was used to prepare the screw hole prior to fixation. A reamer was used to remove all the damaged cartilage from the first metatarsal head and to create a socket for the implant. A second reamer was then used to create a dorsal socket. The trial implant was inserted to assess proper fit and to assess first metatarsal phalangeal joint range of motion. At this time range of motion was not at the desired amount of dorsiflexion, therefore reaming was repeated. After repeating reaming, range of motion was reassessed intraoperatively and noted to be close to the desired 90° dorsiflexion. Using a sagittal saw, rongeur, and power rasp all osteophytes and bony edges were removed. The implant was then inserted and seated using a mallet. Position of the implant was inspected and noted to be flush with all the remaining bone and cartilage surfaces. Range of motion was again assessed intraoperatively and noted to be close to the desired 90° dorsiflexion. Proper placement of the implant was confirmed with C arm intraoperatively.

Hyprocure STJ stent

Attention was directed at the right lateral ankle. The sinus tarsi was located and directly superficial a small horizontal incision was created using a #15 blade scalpel. The incision deepened with sharp and blunt dissection. Care was taken to preserve all vital neurovascular structures. Bleeding vessels were cauterized as necessary with Bovie. All interosseous ligaments were cut and freed using curved tenotomy scissors. The Hyprocure guidewire was placed through the sinus tarsi from lateral to medial in proper anatomical alignment. Tenting was noted at the medial aspect of the ankle confirming correct placement of the guidewire. Proper positioning of the guidewire was also confirmed using C-arm intraoperatively. Hyprocure trial stents were then placed through the subtalar joint following the guidewire beginning at the smallest stent implant size. The trial was gradually increased in size and tested at each for amount of subtalar joint pronation. The size 5 Hyprocure stent was found to be the proper size and fit and confirmed intraoperatively with C-arm. The stent was implanted according to manufacturers guidelines. Correct size and placement was again confirmed with C-arm intraoperatively. Range of motion was accessed after stent placement and noted to be excellent with correction of the hyperpronation deformity. The surgical site was copiously flushed with sterile saline solution. Skin was reapproximated with 4-0 Nylon suture in horizontal suture technique. Clean dressings were applied consisting of Adaptic, Betadine soaked 4x4 guaze, 4x4 guaze, Kling, and Ace Bandage. The tourniquet was deflated at 20 minutes, immediate hyperemia was noted to return to the right lower extremity upon deflation of the cuff. The patient tolerated the procedure and anesthesia well, without complication. The patient was transferred to PACU in stable condition. All sponge and instrument count was correct.

Arthrex Internal Brace

Attention was drawn to the left lateral ankle where incision was made overlying the distal fibula. The incision was deepened with sharp and blunt dissection in all planes. Care was taken to preserve all tendons and neurovascular structures. The peroneal tendons were fully visualized and retracted out of the surgical field. All bleeders were identified and coagulated properly as needed. The inferior retinaculum was carefully dissected and maintained to utilize later in the surgery for the Brostom-Gould technique. Dissection was carried down to the distal fibula and talus, where complete laxity was appreciated due to full thickness tears of the ATFL and CFL ligaments. The periosteum was freed from the distal fibula and portion of the talus. A Arthrex internal brace system was utilized to repair the torn ATFL. Two bone anchors were placed in the distal fibula and one bone ankle containing the internal brace was place in the talus. the two distal fibula bone anchor suture constructed were used to reapproximate the ATFL. One fixated, the internal brace from the talus bone anchor was secured with another anchor into the distal fibula between the previous bone anchors. Direct repair was performed to the CFL using nonabsorbable sutures. The anterior drawer test was performed intraoperatively and noted to normal with significant difference in ankle stability then performed preoperatively. The maintained

inferior retinaculum was secured over the Arthrex internal brace system to complete the Brostom-Gould technique utilizing Vicryl suture.

Keller Bunionectomy

Attention was then directed on the dorsomedial aspect of the first left metatarsophalangeal joint where a 6 cm linear incision was placed directly over the first metatarsophalangeal joint parallel and medial to the course the extensor hallucis longus tendon. The incision was deepened through subcutaneous tissue. All bleeders were identified, cut, clamped, and cauterized. The incision was deepened to the level of the capsule and the periosteum. All the tendons and neurovascular structures were identified and retracted from the site to be preserved. Using sharp and dull dissection, the periosteal and capsular attachments were mobilized from the head of the first metatarsal. A capsulotomy was then performed at the level of the metatarsophalangeal joint. The dorsal medial prominence of the metatarsal head was adequately exposed using sharp dissection and resected with the use of a oscillating saw. Approximately one fourth the base of the proximal phalanx was then resected using oscillating saw. Range of motion was assessed intraoperatively and noted to be adequate. 2-0 Vicryl was used to close the capsule. 4-0 Vicryl was used to close the subcuticular layer and 4-0 nylon was used to close the skin in running interlocking technique. 0.8 cc Decadron was administered around the surgical site for postop pain control. Clean sterile dressings were applied to the patient's foot consisting of Adaptic, 4 x 4 gauze, Kerlix and Coban. At this time the ankle tourniquet was deflated at 48 minutes, immediate hyperemia was noted to the entire left lower extremity upon deflation of the cuff. The patient's left lower extremity was placed into a surgical shoe. The patient was transferred to the recovery room in stable position. All instrument and sponge count was correct.

Lapidus with Staples

Attention was drawn to the right lower extremity where after elevation of the right foot it was exsanguinated by means of an Esmarch bandage. The ankle tourniquet was inflated to 250 mmHg. Attention was drawn to the first MPJ and first tarsometatarsal joint where a long dorsal incision was made overlying the joints. The incision was deepened in all planes of bleeders were identified and coagulated properly. Large tibutary veins of the medial marginal vein at the proximal end of the incision were clamped, cut, and tied with Vicryl suture. Dissection was continued removing capsule and periosteum to expose the first tarsometatarsal joint. After soft tissue was released from the first metatarsal base, the joint was opened and distracted utilizing a small osteotome. After desired correction was visualized, a sagittal saw was used to plane the joint. A larger portion of bone was removed fro the medial cuneiform on the lateral side to correct the IM angle. Desired reduction of the IM angle was confirmed intraoperatively using C-arm and a K-wire was used to maintain positioning. The desired correction was fixated using two Synthes 18 mm staples both dorsally and medially in proper technique.

Lapiplasty

Attention was directed at the first metatarsal cuneiform joint where a dorsal incision was created using a no 15 blade just medial to the extensor hallucis tendon extending from the proximal pole of the medial cuneiform to the midshaft of the first metatarsal. Dissection was deepened through sharp and blunt dissection down to bone at the level of the first tarsometatarsal joint. A small pocket was created laterally for the Lapiplasty fulcrum proximally between the first and second metatarsal. Another small pocket was made plantarly to expose the the medial metatarsal ridge. A sagittal saw was then inserted into the tarsometatarsal joint to plane all joint surfaces. An osteotome was then used to release any remaining plantar ligaments. A small joystick pin was then inserted approximately 1 cm from the base of the first metatarsal. It was decided intraoperatively to better correct the bunion deformity a lateral release would be performed. A small linear incision was created in the first intermetatarsal space with a no. 15 blade and a lateral capsulotomy was performed. Under fluroscopy, using the joystick pin frontal plane motion was checked to ensure complete elimination of the lateral round sign

could be achieved. The Lapiplasty fulcrum was inserted as far proximally and laterally as possible between the base of the first and second metatarsals. The Lapiplasty cut guide was used as a reference to determine the positioner incision over the second metatarsal. Using a no. 15 blade a percutaneous incision was created and the soft tissue was bluntly dissected at the base of the second metatarsal. The Lapiplasty positioner was introduced, the tip of the positioner to the second metatarsal and applying the cup of the positioner to the medial ridge of the metatarsal. The joystick pin was used to rotate the metatarsal while the positioner was being applied. Fluoroscopy was then used intraoperatively to ensure full reduction the triplane deformity and lateral view was checked to ensure the metatarsal was not dorsiflexed. Excellent position in all views was confirmed. A k-wired was then inserted to hold the positioner in place. The joint seeker was placed into the tarsometatarsal joint to set the sagittal plane alignment of the cut guide. The cut guide was then inserted over the joint seeker in alignment with the long axis of the metatarsal. K-wired were then inserted into the cut guide to temporarily hold in place Using sagittal saw, cuts were made following the cut guidepin through the base of the metatarsal and distal cuneiform. Cut guidepin was removed and osteotome was used to remove any remaining plantar attachments and all bone was removed. The Lapiplasty compressor was then applied over the cut guide pins. The compressor device was used to distract the tarsometatarsal joint. All joint spaces were aggressively fenestrated to remove any residual subchondral bone and expose additional bleeding bone for better fusion and healing. All bone chips were left in place to act as autograft during the fusion. The compressor was then used to compress the prepared tarsometatarsal joint spaced together. Excellent apposition of the metatarsal and cuneiform was confirmed using c-arm. The Lapiplasty interfragmental screw was then inserted through the lateral side of the tarsometatarsal joint. A second point of fixation was inserted through the medial side of the joint. Excess bone was removed dorsally and medially using rongeur prior to placement of the plates to ensure each that flush against the bone. The dorsal biplanar plate was placed across the lateral aspect of the joint. Proper positioning of the plate was confirmed with c-arm. The 4 locking screws were then placed following proper AO technique with 12 mm screws in the metatarsal and 14 mm screws in the cuneiform. The medial biplanar plate was then placed across the medial aspect of the joint ensuring the screws would be perpendicular to the screws of the lateral biplanar plate. The 4 locking screws were inserted in the same sequence as the lateral biplanar plate. C-arm was used to confirm triplanar correction and apposition of the joint surfaces. Excellent correction and fixation was confirmed intraoperatively.

MTPJ fusion plate

Attention was then directed to the dorsal aspect of the right 1st metatarsal where a dorsomedial longitudinal incision was made medial to the extensor hallucis longus tendon. The incision was deepened down to the level of subcutaneous tissue. All neurovascular structures were identified and retracted as deemed necessary. All bleeders were identified, cut clamped and cauterized. A lateral release was performed. The incision was deepened through the capsule and all soft tissue structures were then freed about the 1st metatarsal head and the shaft of proximal phalanx. Damage was noted to 1st metatarsal articular surface with hypertrophic bone noted medially and dorsally around the head of the first metatarsal. A power saw was utilized to resect 2mm of the base of the proximal phalanx, perpendicular to the axis of the proximal phalanx, and a similar procedure was performed to the head of the metatarsal. A k wire was then introduced into the center of the metatarsal head. The appropriate size of cannulated metatarsal reamer was found and the metatarsal head and base of the phalanx were reamed according to the manufacturers guidelines. The surgical site was then copiously flushed with sterile saline solution. The right proximal phalanx was dorsiflexed on the metatarsal approximately 20 degrees and the Hallux lock C plate was placed according to the manufacturers guidelines with two 2.7mm locking screws and two 2.7mm nonlocking screws. The fixation was noted to be stable. Next, DBM gel was applied to 1st MPJ. The capsule was then reapproximated with 3-0 vicryl, the subcuticular layer was reapproximated with 4-0 vicryl, and the skin was reapproximated with 4-0 nylon.

Neuroma Excision

Attention was then directed at the right second interspace where a plantar linear incision was made in the skin. Skin was reflected and dissection was carried down to the deep transverse metatarsal ligament through blunt and sharp dissection. All neurovascular structures were identified, preserved, and cauterized as needed. The deep transverse metatarsal ligament was then transected and the enlarged neuroma was identified. The neuroma was excised in toto as proximal as possible. The neuroma was sent as specimen for pathological analysis.

OCD lesion with bone graft

Attention was then directed at the left lateral ankle. The lateral shoulder of the talus was palpated and the defect was appreciated clinically. Using #10 blade scalpel a linear incision was created at the anterior lateral aspect of the ankle. Using sharp and blunt dissection, the incision was carried deep through subcutaneous tissue to the layer of bone. Care was taken to preserve all neurovascular structures. Bleeders were cauterized as necessary with Bovie. The talar defect was clearly visible on the lateral shoulder with disruption of the cartilage in that area. Using sagittal saw, a wedge was dissected that included the entire defect. The osteochondral defect and wedge was removed in total. The resected wedge was used as a template for the correct size graft which was harvested from the fresh frozen talus graft. The bone graft was inserted and fixated into place using an Arthrex absorbable pin. Excellent anatomical size and positioning was appreciated. Range of motion was performed intraoperatively and noted to be smooth. C arm imaging intraoperatively confirmed excellent positioning and fixation. Surgical site was copiously flushed with sterile saline solution. Deep tissue was reapproximated and sutured utilizing 2-0 Vicryl in a simple interrupted manner. Subcutaneous tissues reapproximated and sutured utilizing 3-0 Vicryl in a running locked manner. Skin edges were reapproximated utilizing 2-0 nylon suture in running interlocking technique. Clean sterile dressings were applied to the patient's left foot consisting of Adaptic, 4 x 4 gauze, Kling, web roll, and a posterior splint. The thigh tourniquet was deflated at 44 minutes, immediate hyperemia was noted to the entire left lower extremity upon deflation of the cuff. The patient tolerated the procedure and anesthesia well without complication. The patient was transferred to PACU in stable condition. All sponge and instrument count was correct.

Opening base wedge base plate

The patient was brought to the operating room and placed in the operating table in supine position. The patient was given 2 g IV Ancef prophylactically. After adequate sedation was achieved by the anesthesia team, 12 cc 1:1 mix 0.5% Marcaine plain and 2% Lidocaine plain was administered in Mayo block fashion. A left ankle tourniquet was applied to the left ankle and set at 250 mmHg but not inflated. The left foot was prepped, scrubbed, and draped in normal sterile fashion. Time-out was called to identify the patient's identity and correct surgical site. The left ankle tourniquet was then inflated.

Attention was then directed over the dorsal aspect of the first metatarsal head of the left foot where an approximately 8 cm linear longitudinal skin incision was made medial and parallel to the tendon of the extensor hallucis longus. The incision was deepened through the subcutaneous tissue using sharp and blunt dissection. Care was taken to identify and retract all vital neurovascular structures. All bleeders were ligated and cauterized as necessary. Attention was then directed to the first interspace and a lateral release was performed. Next, a linear longitudinal capsulotomy was performed over the dorsal aspect of the first metatarsal phalangeal joint. The periosteal and capsular structures were then carefully dissected free of the osseous attachments, and the reflected medially and laterally thus exposing the head as well as the shaft of the first metatarsal at the operative site. The medial bump resection was then performed with an oscillating saw.
Attention was then directed to the dorsal aspect of the base of the first metatarsal where a K wire was driven perpendicular to the weightbearing surface of the foot at the medial cortex of the first metatarsal shaft about 1.5 cm distal to the first metatarsal cuneiform joint. K wire was used as a guide for the osteotomy cut. Next, utilizing the oscillating bone saw, an oblique osteotomy was performed medial to lateral, leaving the lateral cortex of bone intact. The osteotomy site was opened using a small straight osteotome. The appropriate Integra

opening wedge plate 3.5mm was selected intraoperatively. The Integra opening wedge plate was purposely bent intraoperatively to accommodate for anatomical variations of metatarsal bone. After the appropriate opening wedge plate was fitted over the osteotomy site, all of wires were used to provisionally fixate the plate. The screw holes were prepped using drill bit included in the Integra sets. Each hole was drilled bicortically and measured utilizing a depth gauge. All of the screws were fixated to 2 finger tightness. Adequate compression and osteotomy placement was confirmed intraoperatively using C arm.

Attention was then directed towards the base of the proximal phalanx of the left foot. The original skin incision was extended proximally to better expose the base of the proximal phalanx. A K wire was introduced from dorsal to plantar in the lateral cortex of the proximal phalanx as a guide for the osteotomy cut. Utilizing the oscillating bone saw, a medial based wedge was removed from the base of the proximal phalanx. The osteotomy was closed using an Integra 8 mm staple. Appropriate correction was confirmed intraoperatively using C arm. The wedge of bone removed for the Akin osteotomy was utilized as bone graft in the opening base wedge osteotomy in the first metatarsal.

The incision site was copiously flushed with sterile saline solution. Closure of the capsule was continued using 2-0 Vicryl. 3-0 Vicryl was then used to suture close the subcuticular layer and lastly skin closure was performed using 4-0 Monocryl suture in subcuticular running fashion. 0.6 cc Dexamethazone was injected around the surgical site for postop pain control and postop inflammation. Clean sterile dressings were applied to the patient's foot consisting of Steri-Strips, betadine soaked Adaptic, 4 x 4 gauze soaked in Betadine, 4 x 4 gauze, and Kling. The ankle tourniquet was deflated at 114 minutes, immediate hyperemia was noted to the entire left extremity upon deflation of the cuff. A short leg fiberglass cast was applied to the patient's left leg. The patient was transferred to the recovery room in stable condition. All instrument and sponge count was correct.

Plantar plate repair

Attention was then directed at the third toe on the left foot. The plantar flexed metatarsal phalangeal joint of the third toe was addressed first. Using a 15 blade a linear incision was created directly over the MPJ. The incision was deepened to the level of the capsule and periosteum. Care was taken to avoid all tendons and neurovascular structures. Using sharp and dull dissection, the periosteal and capsular attachments were mobilized from the head of the third metatarsal. A McGlamry elevator was then used to release the plantar plate adhesions at the joint. Once the head of the metatarsal was completely visualized, a Weil osteotomy was created just inferior to the dorsal aspect of the articular cartilage at an approximately 25 degree angle with respect to the metatarsal shaft. The metatarsal head was shifted back on the osteotomy and temporarily fixated with K wire. A second K wire was then applied to the proximal phalanx, and the joint was distracted open using the Arthrex distractor to visualize the plantar plate. There was a lateral tear noted in the plantar plate with fibrosis with the medial side of the plantar plate intact. Suture tape was passed through the lateral aspect of the plantar plate using the Arthrex Scorpion system according to manufacture guidelines. A second pass was made using the same suture tape through the medial aspect of the plantar plate. The plantar plate was released at this time using a #15 blade. Attention was redirected to the Weil osteotomy. The K wire was removed from the metatarsal, and a Weil osteotomy was permanently fixated using an Arthrex 2.0 snap off screw. Attention was redirected back to the proximal phalanx, a drill hole were created in the center of the base of the proximal phalanx. Using the appropriate Arthrex loop, the suture tape was passed through the respective hole drilled through the proximal phalanx. The toe was held in corrected position and the suture tape was fixated into position using an Arthrex anchor the plantar plate. Attention was then directed at the proximal interphalangeal joint. The incision was deepened using sharp and blunt dissection. All neurovascular structures were identified and preserved. All bleeding vessels were cauterized as necessary with Bovie. A transverse incision was made to the proximal interphalangeal joint capsule and the head of the proximal phalanx was freed of all soft tissue. A sagittal saw was used to remove the head of the proximal phalanx and to remove the cartilage from the base of the middle phalanx. A K wire was used to fixate the correction past from the distal aspect of the digit passing through the

metatarsal phalangeal joint proximally. The incision site was copiously flushed with sterile saline solution. The extensor tendon was reapproximated using Vicryl suture. Capsule closure was performed using 3-0 Vicryl suture. Deep closure was performed using Vicryl suture and lastly skin was reapproximated using 4-0 nylon suture in simple suture technique. The surgical site was dressed with clean sterile dressings consisting of Adaptic, 4 x 4 gauze soaked in Betadine, 4 x 4 gauze, Kling, web roll, and Ace bandage. The right ankle tourniquet was deflated at 61 minutes, immediate hyperemia was noted to return to the entire right lower extremity upon deflation of the cuff. The patient tolerated the procedure and anesthesia well without complication. The patient was transferred to PACU in stable condition. All sponge and instrument count was correct.

Surgical prep right

The patient was brought to the operating room and placed in the operating table in supine position. The patient was given 2 g IV Ancef prophylactically. After adequate sedation was achieved by the anesthesia team, 7-1/2 cc 0.5% Marcaine was administered in Mayo block fashion. A right ankle tourniquet was applied to the right ankle and set at 250 mmHg but not inflated. The right foot was prepped, scrubbed, and draped in normal sterile fashion. Time-out was called to identify the patient's identity and correct surgical site. The right ankle tourniquet was then inflated.

Surgical prep left

The patient was brought to the operating room and placed in the operating table in supine position. The patient was given 2 g IV Ancef prophylactically. After adequate sedation was achieved by the anesthesia team, 12 cc 1:1 mix 0.5% Marcaine plain and 2% Lidocaine plain was administered in Mayo block fashion. A left ankle tourniquet was applied to the left ankle and set at 250 mmHg but not inflated. The left foot was prepped, scrubbed, and draped in normal sterile fashion. Time-out was called to identify the patient's identity and correct surgical site. The left ankle tourniquet was then inflated.

Removal of hardware

Attention was then directed on the dorsal medial aspect of the first left metatarsal shaft over the previous surgical scar. An approximately 6 cm linear incision was made directly parallel and medial to the extensor hallucis longus tendon over the previous surgical scar. The incision was deepened to subcutaneous tissue and previous scar tissue with #15 blade scalpel. Bleeders were identified, cut clamped, and cauterized. The incision was deepened to the level of the periosteum of the first left metatarsal. All tenderness neurovascular structures were identified and retracted from the site to be preserved. Using sharp and dull dissection, the periosteal tissue was mobilized free of attachments on the first left metatarsal shaft. Dissection was carried down to the level of the loose screw and plate fixation. The entrance for the screws and plate was filled with injectable Stryker demineralized bone matrix. Removal of all hardware was confirmed with C arm intraoperatively.

Scarf

Attention was then directed on the dorsomedial aspect of the first left metatarsophalangeal joint where a linear incision was placed directly over the first right metatarsophalangeal joint parallel and medial to the course the extensor hallucis longus tendon to the left great toe. The incision was deepened through subcutaneous tissue. All bleeders were identified, cut, clamped, and cauterized. The incision was deepened to the level of the capsule and the periosteum of the first left metatarsophalangeal joint. All the tendons and neurovascular structures were identified and retracted from the site to be preserved. Using sharp and dull dissection, the periosteal and

capsular attachments were mobilized from the head of the first left metatarsal. The conjoined tendon was identified on the lateral plantar aspect of the base of the proximal phalanx of the left great toe and transversely resected from its insertion. A linear capsulotomy was also performed at the level of the first metatarsophalangeal joint. The medial prominence of the first left metatarsal head was adequately exposed using sharp dissection and resected with the use of a sagittal saw. A scarf Accu cut guide was placed in the center of the shaft of the first metatarsal, and temporarily fixated into place using 2 K wires at the proximal and distal end of the Accu cut system. Using the sagittal saw a scarf osteotomy was created with a long arm through the shaft of the metatarsal, the distal arm exiting through the dorsal portion of the metatarsal, and the proximal portion exiting plantarly through the metatarsal. Care was taken to keep the distal cut in the cancellous bone of the metatarsal head in order to avoid troughing and channeling during lateral displacement. The osteotomy was completed and the head was translated laterally and also rotated slightly to correct the increased PASA. Correction was temporarily maintained with use of bone clamp. The osteotomy was then fixated with 2 Zimmer Biomet threaded 3.4 screws. Correction was assessed intraoperatively, at this time it was decided and Akin osteotomy would be performed for better correction and to centralize the course of the extensor and flexor hallucis longus tendons on the first MPJ. The incision site was extended distally to expose the base of the proximal phalanx. All soft tissue was freed from the base of the proximal phalanx. Following this, using the sagittal saw, an oblique Akin osteotomy was created in the base of the proximal phalanx. Was taken to maintain the lateral cortex, after the wedge was removed, the osteotomy site was closed down medially and fixated with a 2.0 Zimmer Biomet threaded headless cannulated screw. Correction was assessed using C arm intraoperatively. Good range of motion and fixation was appreciated.

Plantar fasciotomy with Smilie knife

Attention was then drawn to the medial aspect of the right heel. Using 18-gauge needle in C arm, the heel spur was located. Once the exact location of the heel spur was appreciated, a small linear incision was created using a #15 blade scalpel. A straight hemostat was introduced through the surgical incision and positioned superiorly and inferiorly to the heel spur and plantar fascia. Again proper location was confirmed using C arm intraoperatively. An additional 4 cc of 2% lidocaine plain was administered. A straight Smiley knife was introduced superiorly and inferiorly to the hemostat and used to release the medial band of the plantar fascia. Release was confirmed intraoperatively with range of motion specifically dorsiflexion of the foot which showed reduced rigidity of the plantar fascia. After the plantar fascia was released, the heel spur was reduced using a bone rasp. Once adequate resection of the spur was completed with use of the rest, the surgical site was inspected with hemostat and using C arm. The surgical site was copiously flushed with normal sterile saline solution. The skin was reapproximated using 4-0 nylon suture in horizontal mattress technique. Clean sterile dressings were applied to the patient's right foot consisting of Betadine soaked Adaptic, 4 x 4 gauze, Kling, and Ace bandage. The patient tolerated the procedure and anesthesia well without complication. The patient was transferred to PACU in stable condition. All sponge and instrument count was correct.

Arthrex speed bridge

The patient was brought to the operating room. General endotracheal anesthesia was administered by the anesthesia team while the patient was still in the stretcher. After the patient was adequately anesthetized, the patient was transferred onto the operating table into the prone position. The patient was given 2 g IV Ancef prophylactically. A right thigh tourniquet was applied to the right thigh and set at 350 mmHg but not inflated. The right foot and lower leg was prepped, scrubbed, and draped in normal sterile fashion. Time-out was called to identify the patient's identity and correct surgical site. The right thigh tourniquet was then inflated.

Attention was then directed at the posterior aspect of the patient's right heel. 10 cc of 0.5% Marcaine plain was administered in local block fashion. Using a #15 blade, a lazy S incision was created on the posterior aspect directly overlying the Achilles tendon and curved medially around the previous skin lesion related to the

deformity. The incision was deepened with sharp and blunt dissection until the Achilles tendon was fully visualized. A T incision was created through the Achilles tendon and it was reflected medially and laterally until the posterior superior heel spur was fully visualized. Using a sagittal saw, exostectomy of the painful bone spur was achieved. All bone removed was passed off the field as specimen. The exostectomy was completed using osteotome and mallet. All remaining sharp edges were removed using rongeur and smoothed with rasp. The surgical site was copiously flushed with sterile saline solution in preparation for speed bridge application. Speed bridge anchor holes were prepared by drilling and tapping with 2 proximal holes and 2 distal holes in the calcaneus. The 2 proximal anchors with suture tape were secured first according to manufacture guidelines. Suture was passed through the Achilles tendon on the appropriate side, one medial and one lateral. One at the time, suture was gathered oner the medial side combined with one from the lateral side and passed through the distal anchor. The Achilles tendon was pulled taut and the distal anchor was secured into place. The same step was then repeated on the opposite side. Intraoperatively the Achilles tendon was found to be securely fashioned and anchored to the calcaneus. All excess fibrotic Achilles tendon was removed using #15 blade. The Achilles tendon was repaired using Ethibond suture in running technique. The surgical site was copiously flushed with sterile saline solution. Subcutaneous closure was performed using Vicryl suture and lastly skin was reapproximated using Nlon suture in running interlocking technique. The surgical site was dressed with Xeroform, 4 x 4 gauze soaked in Betadine, 4 x 4 gauze, and Kling. The right thigh tourniquet was deflated at 61 minutes, immediate hyperemia was noted to return to the right lower extremity upon deflation of the cuff. Short leg cast was applied to the right lower extremity. The patient was then transferred from the operating table back to the stretcher into supine position. The patient tolerated the procedure and anesthesia well, without complication. The patient was transferred to PACU in stable condition. All sponge and instrument counts correct.

STJ fusion

Attention was then directed at the sinus tarsi of the right ankle. The location of the sinus tarsi was confirmed with use of spinal needle. Using a #10 blade a curvilinear incision was created extending from the posterior inferior aspect of the fibula to the calcaneocuboid joint. Using a #15 blade, the incision was deepened to subcutaneous tissue with sharp and blunt dissection. Care was taken to preserve all vital tendons and neurovascular structures. The deep fascia was identified and incised along the inferior border of the extensor digitorum brevis muscle. The muscle was reflected away from the surgical field with use #15 blade. All intraosseous ligaments were released with use of small surgical scissors. The subtalar joint was distracted with the use of small laminar spreader and the anterior, middle, and posterior facets were clearly visualized. Cartilaginous fragments were noted within the subtalar joint area from severe end-stage subtalar joint arthritis. All the flaking pieces were removed from the surgical site. Each of the facets were denuded of cartilage with use of sagittal saw, osteotome and mallet, and power burr. Positioning of the fusion site was confirmed with the use of C arm intraoperatively. When good alignment was obtained, temporary fixation was achieved with use of Synthes K wire positioned from the anterior talar neck to the posterior lateral aspect of the calcaneus. Positioning of the fixation was again confirmed using C-arm intraoperatively. The calcaneus was held and slightly everted position and a 6.5 mm Synthes cannulated screw was used to fixate the fusion site. A second 6.5 millimeter screw was then introduced just distal to the first screw to prevent rotation. Final fixation was confirmed with use of C arm intraoperatively and excellent fixation and fusion was noted. The surgical site was copiously flushed with sterile saline solution. Deep closure was achieved with Vicryl suture, followed by subcutaneous closure with Vicryl suture, and lastly skin was reapproximated with use of nylon suture in running interlocking technique. Clean sterile dressings were applied to the surgical site consisting of Adaptic, 4 x 4 gauze, Kling, and short leg cast. The right ankle tourniquet was deflated at 48 minutes, immediate hyperemia was noted to return to the entire right lower extremity upon deflation of the cuff. The patient tolerated the procedure and anesthesia well, without complication. The patient was transferred to PACU in stable condition. All sponge and instrument count was correct.

Tarsal tunnel syndrome

Attention was then directed to the medial aspect of the right ankle. Using #10 blade a curvilinear skin incision was created just posterior to the medial malleolus. Using sharp and blunt dissection the incision was deepened through subcutaneous tissue. Care was taken to preserve all vital neurovascular structures. All bleeding vessels were cauterized with Bovie as necessary. The incision was carefully deepened through flexor retinaculum until the posterior tibial nerve was clearly visualized. The nerve was notably inflamed. Vessel loops were looped around the posterior tibial nerve for visualization. Using Metzenbaum scissors, the posterior tibial nerve was followed distally and released from all soft tissue entrapment. The nerve was traced distally into the porta pedis where the abductor hallucis was notably and trapping the nerve. The abductor hallucis was released using surgical scissors and the nerve was confirmed free after this release. The posterior tibial nerve was now traced proximally and released of all soft tissue entrapments including all remaining retinaculum. After all soft tissue entrapments were released, the posterior tibial nerve was again traced from proximal to distal to confirm all entrapments were released. A small amount of 0.5% Marcaine plain and dexamethasone was injected intraneurally into the epineurium. Care was taken to position the small needle with the bevel proximal and introduced at an angle just under the epineurium. The surgical site was copiously flushed with sterile saline solution. The retinaculum was not reapproximated to prevent future entrapments. Subcutaneous closure was performed using 2-0 Vicryl suture. Skin was reapproximated using 2-0 nylon suture in running interlocking technique. Clean sterile dressings were applied to the surgical site consisting of Adaptic, 4 x 4 gauze, Kling, and short leg cast. The thigh tourniquet was deflated at 16 minutes, immediate hyperemia was noted to return to the entire right lower extremity upon deflation of the cuff. The patient tolerated the procedure and anesthesia well, without complication. The patient was transferred to PACU in stable condition. All sponge and instrument count was correct.

Syndesmosis tightrope

After the comminuted fibular fracture was addressed, the syndesmosis was inspected for injury. Stress x-rays were performed using fluoroscopy intraoperatively. Gapping of the syndesmosis was noted and required surgical fixation. A guidewire was introduced from lateral to medial through one of the proximal plate holes until tenting was observed on the medial side of the ankle. Desired location was confirmed using C arm. The guidewire was introduced approximately 1.5 cm above the ankle joint in the trans-malleolar plane. Next, the Arthrex cannulated drill bit was used to predrill the tight rope hole. Once desired positioning was achieved, the Arthrex tight rope insertion needle was advanced through the predrilled hole and confirmed to be on the medial aspect of the tibia using fluoroscopy. The Arthrex tight rope device was deployed and tightened utilizing tensioning handles. Both the medial and lateral button of the tight rope were confirmed to be flush against the bone utilizing C arm. The remaining suture was cut flush to the lateral button using a #15 blade scalpel.

TMA with TAL

A 15 blade was used to make 3 percutaneous incisions, 2 cm apart starting 2 cm proximal to the insertion of the achilles tendon. The incisions were stab incisions into the center of the achilles tendon, the proximal incision was made into the center of the achilles tendon then the 15 blade then turned medial and cut through the medial aspect of the TAL, the central incision was made into the center of the achilles tendon, then the blade was turned laterally and cut through the lateral aspect of the TAL, and the distal incision was made into the center of the achilles tendon, then the blade was turned medially and cut through the medial aspect of the TAL. Dorsiflexion ROM was then tested and a marked improvement was noted intraoperatively. 4-0 nylon was used to close the incisions with simple suturing technique.

The foot was then removed from the mayo stand. A 10 blade was used to make a fish-mouth incision, with the dorsal aspect of the incision made just proximal the the MPJ's and the plantar aspect of the incision just

proximal to the digits sulcus and around a submet 3 plantar wound, which was noted to have purulent drainage before being excised in toto. Care was taken to ensure the incision was made down to bone and in a single plane. Using a periosteal elevator, soft tissue attachments were removed from the metatarsals. It was noted that there was good bleeding at this time. Next, a sagittal saw was used to resect the distal aspects of the second, third, fourth, and fifth metatarsal shafts, which were then sent for C & S, as well as pathology. Care was taken to ensure there was no plantar shelves and the edges of the metatarsal were beveled. The remaining metatarsal bones were inspected and the cortex was solid. A clean margin was taken off the third metatarsal and sent to pathology. Next all tendons were clamped, pulled distally and cut, and any tissue which appeared non viable was resected. Wound cultures were taken at this time. Next, a pulse lavage with vancomycin infused saline solution was used on the incision site. The incision site was inspected again for the appearance of any non viable tissue. Next, a plantar muscle flap was performed and the plantar flap was secured with 3-0 vicryl. Next, skin staples were used to reapproximate the skin, though the area of skin on the plantar flap which had been excised due to the plantar wound was left open and packed with 1/4 inch iodoform packing.

Stryker ToeTac implant

Attention was again directed at the right second toe. A 0.045 inch K wire was introduced into the center of the proximal phalanx. The head of the proximal phalanx was denuded of cartilage in preparation for the implant using the Stryker reamer system. The base of the middle phalanx of the second toe was also denuded of cartilage using the appropriate Stryker reamer. Next, the head of the proximal phalanx and base of the middle phalanx were predrilled for the implant using the appropriate cannulated drill bit. The Stryker toe Tac implant was then introduced into the base of the middle phalanx and the head of the proximal phalanx. The implant was compressed until the bones were approximated and arthrodesis was achieved. The K wire was left in place to further hold the arthrodesis. Desired implant placement was confirmed using C arm intraoperatively. The above steps and implant placement was repeated on the right third toe in toto.

Trimalleolar fracture

Patient was placed supine on the operating table with all bony prominence as well padded. Following intubation a well-padded tourniquet was placed on the right proximal thigh and the lower extremity was prepped in sterile fashion.

A time-out was performed to confirm the identity of patient, the operative site, the operative procedure, and the receipt of IV antibiotics within 1 hour prior to making skin incision.

Operative extremity was exsanguinated and the tourniquet was inflated to 350 mmHg.

All appropriate bony and soft tissue landmarks were identified. A longitudinal skin incision was made over the lateral malleolus. Dissection was carried sharply through the skin and subcutaneous tissues. Thick soft tissue flaps were developed to be dissected directly down onto the lateral malleolus. Care was taken to protect the peroneal tendon posteriorly. Fracture was identified and found to be a spiral fracture that was shortened and externally rotated with minimal comminution anteriorly. Fracture was debrided with a curette and rongeur. Fracture was irrigated with normal saline.

We next performed open reduction internal fixation of the right ankle lateral malleolus fracture. Using bony reduction forceps the ankle was manipulated and the fracture was reduced to anatomic alignment. Alignment was confirmed under fluoroscopic imaging. A 3.5 mm cortical lag screw was placed from anterior to posterior using lag technique. This gave satisfactory initial fixation. A 7 hole Zimmer one third tubular plate was then contoured and applied the lateral aspect of the fibula. Plate was secured with 3, 2.5 mm, bicortical cortical screws proximally, 1, 2.7 locking screw proximally, and 2, 2.7 mm, locking screws distally. All screws had

excellent fixation.

We next performed open reduction and fixation of the right ankle medial malleolus fracture. Longitudinal skin incision was made over the tip of the medial malleolus. Dissection was carried sharply through skin and subcutaneous tissues. Care was taken to identify and protect the greater saphenous vein. Fracture was gently debrided and irrigated with normal saline. Fracture was reduced with a dental pick. Under fluoroscopic guidance to parallel K wires were placed across the fracture, one anterior and one posterior. 2 partially threaded 4.0 mm cancellus screws, each measuring 46 mm, were placed. Each screw had excellent fixation. Final fluoroscopic images were obtained to confirm that the fracture was anatomically aligned with hardware in good position. A cotton test was performed to assess the syndesmosis, which was stable.

Wounds were irrigated with normal saline. Deep layer was closed with 0 Vicryl. Subcutaneous tissues were closed with 2-0 Vicryl. Skin incisions were closed with 4-0 Monocryl. 10 cc of 0.5% ropivacaine was injected into the skin incision medially. A sterile aquacel dressing and a well-padded posterior splint with the ankle in neutral dorsiflexion were applied.

Tourniquet was deflated.

All instrument and sponge counts were correct.

Patient was awoken from anesthesia and taken to the PACU in stable condition.

Wart excision

Patient was taken to the OR and prepped and draped in usual sterile manner. Changes drawn to right lower extremity with elevation of the right foot the foot was exsanguinated by means of an Esmarch bandage. The ankle tourniquet was inflated to 250 mmHg. Attention was drawn to the plantar aspect of the right foot where a 15 blade was used to circumscribe the lesion the lesion was then curetted free from its attachments to the subcutaneous tissue. The base was cauterized with the Bovie. No complications were noted. A dry sterile dressing was applied to the right foot and tourniquet was deflated. Total tourniquet time was 5 minutes. Normal color temperature vascularity is noted to return the digits of the right foot.

Weil

Attention was then directed at the second toe on the left foot. The plantar flexed MPJ of the second toe was addressed first. Using a 15 blade a linear incision was created directly over the MPJ. The incision was deepened to the level of the capsule and periosteum. Care was taken to avoid all tendons and neurovascular structures. Using sharp and dull dissection, the periosteal and capsular attachments were mobilized from the head of the second metatarsal. A McGlamry elevator was then used to release the plantar plate adhesions at the joint. Once the head of the metatarsal was completely visualized, a Weil osteotomy was created just inferior to the dorsal aspect of the arch articular cartilage at an approximately 25 degree angle with respect to the metatarsal shaft. The osteotomy was fixated with 2.0 Zimmer Biomet twist off screws x 2.

Comprehensive history and physical examinations:

Admission, preoperative, and outpatient H&P's may be used as acceptable forms of a comprehensive H&P.

A problem-focused history and physical examination does not fulfill this requirement.

The resident must demonstrate competency through a diversity of comprehensive history and physical examinations that also include evaluations in the diagnostic medicine evaluation categories.

The resident must develop the ability to utilize information obtained from the history and physical examination and ancillary studies to arrive at an appropriate diagnosis and treatment plan.

Documentation of the approach to treatment must reflect adequate investigation, observation, and judgment.

LOGGING OF NON-SURGICAL CASES:

Comprehensive H&Ps

Residents are given the opportunity to complete their H&P MAV during their first year during the hospitalist, Internal Medicine, and Emergency rotations. These cases should be completed (>50) by the end of the PGY-1 year.

Biomechanical Examinations

There is an abundance of biomechanical examinations to be completed as part of your clinic rotations. These cases should be recorded and completed (>50) by the end of the PGY-2 year.

Podopediatric cases

Any surgical or non-surgical patient 18 years of age or younger should be logged as a pediatric case as long as the lower extremity is the chief area of concern.

These cases (>25) must be completed by the end of your residency experience.

Trauma cases

Make certain to log these cases that are surgical treatments of traumatic injuries by checking the appropriate trauma box in your surgical log. They will count as a surgical case and a trauma case. If two residents are scrubbed on the case, one resident can claim credit for the surgery and one can claim credit for the trauma, both cannot claim both. Nonsurgical trauma cases seen on your ortho rotation or in the ED or podiatry clinic should be logged as trauma as well.

At least 25 of the 50 required trauma cases must be foot and or ankle trauma.

Interesting cases seen on non-podiatric rotations

Log any cases surgical and nonsurgical in the appropriate category to show diversity of your experiences.

Clinic office encounters

Log clinic cases and procedures during those rotations to accumulate at least 1000 encounters.

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Council on Podiatric Medical Education

July 2023

TO: Program Directors and Residents
FROM: Council on Podiatric Medical Education
SUBJECT: Proper Logging Guide

- The new guidelines are effective July 1, 2023, to allow for updates to the CLAD report in Podiatry Residency Resource.
- New sections added include the following:
  - Category 6 – Other Podiatric Procedures
  - Category 11 – Lower Extremity Wound Care
  - Category 13 – Other Clinical Experiences

All logged procedures, biomechanical examinations, and comprehensive history and physical exams must comply with these guidelines beginning July 1, 2023.

Proper Logging Guide
(*Effective July 1,2023*)

GENERAL GUIDELINES:

1) For the procedure codes listed below, the program director must review each entry to determine proper usage. The following surgical codes may only be used if a more appropriate procedure does not exist. A full documentation in the "Procedure Note" is required to justify use.

    1.13 other osseous digital procedure not listed above
    2.3.10 other first ray procedure not listed above
    3.14 other soft tissue procedures not listed above (limited to the foot)
    4.18 other osseous procedures not listed (distal to the tarsometatarsal joint)
    5.1.9 other elective reconstructive rearfoot/ankle soft-tissue surgery not listed above
    5.2.11 other elective reconstructive rearfoot/ankle osseous surgery not listed above
    5.3.7 other non-elective reconstructive rearfoot/ankle soft tissue surgery not listed above
    5.4.8 other non-elective reconstructive rearfoot/ankle osseous surgery not listed above

2) In cases where a subchondroplasty procedure is performed as part of another procedure, only the index procedure must be logged. For example, a talar dome or distal tibial subchondroplasty may only be logged as:

    5.2.1 Operative arthroscopy without removal of loose body or other osteochondral debridement

    5.2.7 open management of talar dome lesion (with or without osteotomy) or

    5.2.8 ankle arthrotomy / arthroscopy with removal of loose body or other osteochondral debridement.

    If subchondroplasty is performed in isolation, the appropriate logging mandates use of the following subcategories: 5.2.7, 5.2.8

        1.13 other osseous digital procedure not listed above
        2.3.10 other first ray procedure not listed above
        4.18 other osseous procedures not list (distal to the tarsometatarsal joint)
        5.2.11 other elective reconstructive rearfoot/ankle osseous surgery not listed above

3) Laterality (left or right) must be selected for all surgical procedures in categories 1 through 5.

4) The "Procedure Notes" must always reflect additional procedures that were performed but not logged individually.

5) Procedures may not be fragmented or unbundled into individual component parts to allow more than one resident to claim first assist.

6) Any reference in this document to "midfoot" entails any osseous or soft tissue procedure that is performed proximal to but not including the tarsometatarsal/Lisfranc joint.

Category 1: Digital Surgery (lesser toe or hallux)

A procedure performed at the PIPJ and DIPJ can only be logged once. Include both procedures in the procedure notes.

- A resident may only log one category 1 procedure per toe (the Procedure Note may reflect additional procedures performed) and no more than one resident may claim a first assistant on a single toe.
- The digit (toe) number must be documented for all digital surgical procedures.

1.6 Phalangeal Osteotomy

- **May not** be used in conjunction with:
  - 2.1.1 bunionectomy (partial ostectomy/Silver procedure) – (use 2.1.3 bunionectomy with hallux osteotomy)
  - 2.1.3 bunionectomy with phalangeal osteotomy
  - 2.1.7 metatarsophalangeal joint (MPJ) fusion
  - 2.1.8 MPJ implant (with phalangeal implantation)
  - 2.2.1 cheilectomy
  - 2.2.2 joint salvage with phalangeal osteotomy (Kessel-Bonney, enclavement)
  - 2.2.6 MPJ fusion
  - 2.2.7 MPJ implant (with phalangeal implantation)
  - 2.3.4 amputation

- **May** be used as an "add on" in conjunction with:
  - 2.1.4 bunionectomy with distal first metatarsal osteotomy
  - 2.1.5 bunionectomy with first metatarsal base or shaft osteotomy
  - 2.1.6 bunionectomy with first metatarsocuneiform fusion
  - 2.1.8 MPJ implant (when used, a metatarsal component implantation only)
  - 2.1.9 MPJ arthroplasty
  - 2.1.10 bunionectomy with double correction with osteotomy and/or arthrodesis
  - 2.2.3 joint salvage with distal metatarsal osteotomy
  - 2.2.4 joint salvage with first metatarsal shaft or base osteotomy
  - 2.2.5 joint salvage with first metatarsocuneiform fusion
  - 2.2.7 MPJ implant (when used, a metatarsal component implantation only)
  - 2.2.8 MPJ arthroplasty
  - 2.3.1 tendon transfer/lengthening/procedure
  - 2.3.2 osteotomy (e.g., dorsiflexory)
  - 2.3.3 metatarsocuneiform fusion (other than for hallux valgus or hallux limitus)
  - 2.3.5 management of osseous tumor/neoplasm (with or without bone graft)
  - 2.3.7 open management of fracture or MPJ dislocation
  - 2.3.8 corticotomy/callus distraction
  - 2.3.9 revision/repair of surgical outcome (e.g., non-union, hallux varus)
  - 2.3.10 other first ray procedure not listed above (only as indicated)

1.8 Amputation

- **May not** be used in conjunction with the following procedures if in reference to the same numerical ray:
  - 1.10 management of bone/joint infection
  - 2.3.4 amputation
  - 2.3.6 management of bone/joint infection (with or without bone graft)
  - 3.8 incision and drainage of soft tissue
  - 4.4 metatarsal head resection (single or multiple)
  - 4.10 amputation (lesser ray, transmetatarsal amputation)

1.10 Management of Bone/joint Infection

- **May not** be used in conjunction with:
  - 1.8 amputation (if done on the same digit)
  - 3.8 incision and drainage of soft tissue infection (includes foot, ankle or leg)

Category 2: First Ray Surgery

In general:

- The soft tissue component **of *all* First Ray Surgery** repair is inclusive and is **not** separately claimed as an additional procedure for all subcategories. The use of 2.1.1 is limited to isolated soft tissue repair/partial ostectomy of the first MPJ when no other osteotomy or fusion procedure is completed on the first ray.

- A resident **may** only log one 2.2.1-2.3.10 procedure per foot and no more than one resident may claim a first assistant procedure per foot.

Hallux Valgus Surgery

- Osteotomy (Akin) of the proximal phalanx treatment, see above in Digital Surgery
- Use of suture and button construct as the primary method to repair a bunion deformity should be logged as 2.1.1
- 2.1.10 can only be used when two separate osteotomies and/or arthrodesis are performed on the same first ray to correct the bunion deformity. EXAMPLE: A first tarsometatarsal arthrodesis and a head osteotomy on the same metatarsal should be logged as 2.1.10.

Hallux Limitus Surgery

- All of these procedures **shall be inclusive** and count as **one First Ray Surgery** procedure

Other First Ray Surgery

2.3.1 Tendon Transfer/lengthening Procedure

- The soft tissue component of all first ray surgery repair is inclusive and is not separately claimed as an additional procedure.

2.3.4 Amputation

- **May not** be used in conjunction with:
  2.3.6 management of bone/joint infection (with or without bone graft)
  3.8 incision and drainage of soft tissue infection (includes foot, ankle or leg)

2.3.5 Management of Osseous Tumor/neoplasm (with or without bone graft)

- **May not** be used for removal of simple bone cyst

2.3.6 Management of Bone/joint Infection (with or without bone graft)

- **May not** be used in conjunction with:
  1.8 amputation (if the amputation involves the great toe)
  2.3.4 amputation
  3.8 incision and drainage of soft tissue infection (includes foot, ankle, or leg)

2.3.10 Other First Ray Procedures Not Listed Above

- When two separate procedures are performed on the same first ray to correct the bunion deformity, please use 2.1.10.
- **EXAMPLE**: A first tarsometatarsal arthrodesis and a head osteotomy on the same metatarsal should be logged as 2.1.10.

Category 3: Other Soft Tissue Foot Surgery:

3.1 Excision of Ossicle/sesamoid

- Can only be used if it is performed as an isolated primary procedure
- **May not** be used in conjunction with First Ray Surgery or tendon transfer/augmentation
- **May not** be used in conjunction with Other Osseous Foot Surgery
- **EXAMPLES**: os peroneum, os tibiale externum, os vesalianum

3.4 Plantar Fasciotomy

- May include open, endoscopic, or minimal incision approach
- TOPAZ and PRP injection are logged as 6.14
- Includes localized lipectomy and associated soft tissue excision
- Includes plantar heel spur/exostosis resection
- Includes local nerve (i.e. Baxter's nerve) release or ablation
- **May not** be claimed as Reconstructive Rearfoot/Ankle Surgery
- May not be used in conjunction with:
  - 3.9 plantar fasciectomy /plantar fibroma resection

3.5 Lesser MPJ Capsulotendon Balancing

- Excludes percutaneous tenotomy/capsulotomy
- **May not** be used in conjunction with:
  - 3.6 tendon repair, lengthening, or transfer involving the forefoot (including digital flexor digitorum longus transfer)
  - 3.7 open management of dislocation (MPJ/tarsometatarsal)
  - 4.2 lesser MPJ arthroplasty
  - 4.3 bunionectomy of the fifth metatarsal without osteotomy
  - 4.5 lesser MPJ implant
  - 4.6 central metatarsal osteotomy
  - 4.7 bunionectomy of the fifth metatarsal with osteotomy

3.6 Tendon Repair, Lengthening, or Transfer Involving the Forefoot (including digital flexor digitorum longus transfer)

- **May not** be used in conjunction with
  - 3.5 lesser MPJ capsulotendon balancing
  - 3.7 open Management of dislocation (MPJ/tarsometatarsal)
  - 4.2 lesser MPJ arthroplasty
- **May not** be used if percutaneous

3.7 Open Management of Dislocation (MPJ/tarsometatarsal)

- **May** be claimed as an additional procedure in conjunction with Digital Surgery.
- Includes plantar plate repair and soft tissue repair of LisFranc injury
- **May not** be used if percutaneous
- **May not** be used in conjunction with
  - 3.5 lesser MPJ capsulotendon balancing
  - 3.6 tendon repair, lengthening, or transfer involving the forefoot (including digital flexor digitorum longus transfer)
  - 4.2 lesser MPJ arthroplasty
  - 4.13 open management of tarsometatarsal fracture/dislocation
  - 4.15 tarsometatarsal fusion
- Can be used with digital procedure and lesser metatarsal osteotomy

3.8 Incision and Drainage/wide debridement of Soft Tissue Infection (includes foot, ankle, or leg)

- Full documentation in the "Procedure Note" to justify use of procedure 3.8 with another procedure is required.
- If an I&D performed at a different site as an amputation, can be logged separately.

EXAMPLE: an I&D of a first interspace with a 5th digit amputation

- If the I&D, amputation, and bone biopsy are all occurring at the same surgical site, only one of these procedures may be logged.

- **May not** be used in conjunction with:
  - 1.8 amputation
  - 1.10 management of bone/joint infection
  - 2.3.4 amputation
  - 2.3.6 management of bone/joint infection (with or without bone graft)
  - 3.12 plastic surgery techniques
  - 3.17 decompression of compartment syndrome (includes foot or leg)
  - 4.4 metatarsal head resection (single or multiple)
  - 4.10 amputation (lesser ray, tarsometatarsal amputation)
  - 4.11 management of bone/joint infection distal to the tarsometatarsal joints (with or without bone graft)
  - 5.1.1 plastic surgery techniques involving the midfoot, rearfoot, or ankle
  - 5.4.6 management of bone/joint infection (with or without bone graft)
  - 5.4.7 amputation proximal to the tarsometatarsal joints

- This is inclusive of distal plantar space infection and therefore **may not** be claimed as Reconstructive Rearfoot/Ankle Surgery

3.9 Plantar Fasciectomy

- Includes localized lipectomy or soft tissue excisions and includes the heel spur (exostectomy) resection
- **May not** be claimed as Reconstructive Rearfoot/Ankle Surgery
- TOPAZ and PRP injection are logged as 6.14
- **May not** be used in conjunction with:
  - 3.4 plantar fasciotomy

3.10 Excision of Soft Tissue tumor/mass (without reconstructive surgery; includes foot, ankle, or leg)

- **EXAMPLE**S: Excision of a ganglion cyst in the foot, sinus tarsi decompression
- Excision of verrucae or other skin lesion is excluded (use 6.2)

3.12 Plastic Surgery Techniques (including skin graft, skin plasty, flaps, syndactylization, desyndactylization, and debulking procedures limited to the forefoot)

- Excludes synthetic/Biologic grafts (use 6.7)
- Excludes elliptical or wedge excisions such as a derotational 5th toe arthroplasty
- Full documentation in the Procedure Note to justify the extent of 3.12 is required
- The harvesting and application of skin graft/flap count as one procedure
- **May be** used in conjunction with Digital Surgery and in conjunction with 3.5 (lesser MPJ capsulotendon balancing), when **extensive**, such as to correct severe digital deformities, i.e. Muir-Ruiz
- Wound bed preparation/debridement is included in this procedure

3.13 Microscopic Nerve/vascular Repair (forefoot only)

- Requires the use of microscopic equipment / loupes

3.14 Other Soft Tissue Procedures Not Listed Above (limited to the foot)

- Harvesting of split thickness skin grafts (STSG) from any source (i.e., foot, ankle, leg, or thigh) and application of the graft to the foot or ankle should be logged as 3.12, 5.1.1 or 5.3.4

3.16 External Neurolysis/decompression (including tarsal tunnel)

- Multiple nerve decompressions of the same extremity are logged as **one** procedure

Category 4: Other Osseous Foot Surgery:

- **One procedure per metatarsal. Exceptions are noted below.**

4.1 Partial Ostectomy (includes foot, ankle, or leg)

- **May** include calcaneal ostectomies, i.e. simple Haglund's excision, retrocalcaneal exostectomy and resection of os trigonum (see 4.19 below)

- **May not** be used in conjunction with:
  - 3.4 plantar fasciotomy if associated with plantar calcaneal exostosis (see 3.4 above)
  - 3.9 plantar fasciectomy if associated with plantar calcaneal exostosis (see 3.9 above)
  - 4.2 lesser MPJ arthroplasty, if associated with the same metatarsal
  - 4.3 bunionectomy of the fifth metatarsal without osteotomy, if associated with the same metatarsal
  - 4.5 lesser MPJ implant, if associated with the same metatarsal
  - 4.6 central metatarsal osteotomy, if associated with the same metatarsal
  - 4.7 bunionectomy of the fifth metatarsal with osteotomy, if associated with the same metatarsal

4.2 Lesser MPJ Arthroplasty

- **May not** be used in conjunction with:
  - 3.5 lesser MPJ capsulotendon balancing
  - 3.6 tendon repair, lengthening, or transfer involving the forefoot
  - 3.7 open management of dislocation (MPJ/tasometatarsal
  - 4.1 partial ostectomy (includes foot, ankle or leg)
  - 4.3 bunionectomy of the fifth metatarsal without osteotomy
  - 4.4 metatarsal head resection (single or multiple)
  - 4.5 lesser MPJ implant
  - 4.6 central metatarsal osteotomy
  - 4.7 bunionectomy of the fifth metatarsal with osteotomy

4.4 Metatarsal Head Resection (single or multiple)

- single, multiple, or adjoining metatarsal head resections are considered as one procedure

- non-adjoining metatarsal head resections can be counted as two procedures with procedure note documentation.

EXAMPLE: 1st and 5th metatarsal head resection

- adjoining metatarsal head resections are considered as one procedure

4.6 Central Metatarsal Osteotomy

- May be used in conjunction with 3.7, plantar plate repair, if performed at the same location

4.8 Open Management of Lesser Metatarsal Fracture(s)

- Repair of multiple metatarsal fractures is logged as individual procedures

4.10 Amputation (lesser ray, transmetatarsal amputation)

- Transmetatarsal amputation is considered as one procedure
- Amputation of adjoining metatarsals or rays are considered one procedure
- Non-adjoining metatarsal ray amputations can be counted as two procedures

EXAMPLE, 1st and 5th ray amputations

- Lesser ray amputation **includes** the amputation of the toe(s) and metatarsal(s) segment(s)
- **Includes** the incision and drainage

4.11 Management of Bone/joint Infection Distal to the Tarsometatarsal Joints (with or without bone graft)

- Full documentation in the "Procedure Note" to justify use of procedure 4.11 with another procedure is required.

4.13 Open Management of Tarsometatarsal Fracture/dislocation

- Claimed as one procedure for repair of the metatarsal cuneiform and cuboid joints. Also inclusive of the first metatarsal cuneiform joint
- Cannot be logged with 3.7 open management of dislocation (MPJ/tarsometatarsal) or 4.15 tarsometatarsal fusion

4.14 Multiple Metatarsal Osteotomy Management of Metatarsus Adductus

- One procedure for the correction of metatarsus adductus (independent of the number of osteotomies performed)

4.15 Tarsometatarsal Fusion

- Fusion of the tarsometatarsal joints (complete or partial) is **one** procedure
- This code is to be used in cases of Lisfranc joint ORIF or osteoarthritis. **Cannot** be logged with 3.7 open management of dislocation (MPJ / tarsometatarsal) or 4.13 open management of tarsometatarsal fracture dislocation.
- This code is not to be used for bunion correction (use 2.1.6 or 2.2.6 or 2.3.3)

4.17 Revision/repair of Surgical Outcome in the Forefoot

- Full documentation in the "Procedure Note" to justify use of procedure 4.17 with another procedure is required.

4.19 Detachment/reattachment of Achilles Tendon with Partial Ostectomy

- **May not** be used in conjunction with:
  - 4.1 partial ostectomy (includes foot, ankle or leg)
  - 5.3.1 repair of acute tendon injury

Category 5: Reconstructive Rearfoot/Ankle Surgery:

- Any reference in this document to "midfoot" entails any osseous or soft tissue procedure that is performed proximal to, but not including the tarsometatarsal/Lisfranc joint.

- The rule of thumb to follow when logging ankle procedures is, "an ankle is an ankle." This means that all procedures performed within a single case must be logged as a single procedure, even if one could log multiple procedures if they were performed at different times. Exceptions are noted below.

Elective – Soft tissue:

5.1.1 Plastic Surgery Techniques Involving the Midfoot, Rearfoot, or Ankle

- **May not** include skin plasty repair that utilizes just ellipses/wedges.
- Documentation of details in the procedure note is required.
- The harvesting and application of skin graft/flap count as **one** procedure.
- Wound bed preparation/debridement is included in this procedure

5.1.2 Tendon Transfer Involving the Midfoot, Rearfoot, Ankle, or Leg

- Any tendon transfer except plantaris with an Achilles tendon repair is acceptable (logged as two procedures)
- **May not** be used in conjunction with:
  5.1.4 soft tissue repair of complex congenital foot/ankle deformity (clubfoot, vertical talus)

<u>See 5.1.5</u>

- **Does not** include digital tendon transfers i.e., FDL, Hibbs procedure etc.

5.1.3 Tendon Lengthening Involving the Midfoot, Rearfoot, Ankle, or Leg

- **May** include percutaneous or "stab" type lengthening (e.g., percutaneous tendon Achilles lengthening)
- **Does not** include digital tendon transfers i.e., FDL, Hibbs procedure etc.

5.1.5 Primary or Secondary Repair of Ligamentous Structures

- **Repair of multiple ligaments in the same ankle are logged as one procedure**
- **May** be used in conjunction with:
  5.1.2 tendon transfer involving the midfoot, rearfoot, ankle or leg
  5.1.6 ligament or tendon augmentation/supplementation/restoration

5.1.6 Tendon Augmentation/supplementation/restoration

- Includes excision of an ossicle or ostectomy

EXAMPLE: Os peroneum with a peroneal tendon repair and Os tibiale Externum with a kidner

- Repair of both peroneal tendons at the same time is counted as one procedure
- **May not** be used in conjunction with:
  5.1.2 tendon transfer involving the midfoot, rearfoot, ankle or leg
- **Does not** include digital tendon transfers i.e., FDL, Hibbs procedure etc. (see 3.6 above)

5.1.7 Open Synovectomy of the Rearfoot/ankle

- **May not** be used in conjunction with:
  5.2.1 operative arthroscopy without removal of loose body or other osteochondral debridement
  5.2.7 open management of talar dome lesion (with or without osteotomy)
  5.2.8 ankle arthrotomy / arthroscopy with removal of loose body or other osteochondral debridement
  5.2.9 ankle implant

Elective – Osseous:

5.2.1 Operative Arthroscopy without removal of loose body or other osteochondral debridement

- Cannot be separately counted when converted into an open ankle procedure

- Can be logged with medial or lateral ankle stabilization as long as the ankle stabilization was not performed through the scope
- **May not** be claimed as a diagnostic arthroscopy or if the arthroscopy results in an "open" procedure.
- **May not** be claimed in conjunction with:
  5.1.7 open synovectomy of the rearfoot/ankle
  5.2.7 open management of talar dome lesion (with or without osteotomy)
  5.2.8 ankle arthrotomy with removal of loose body or other osteochondral debridement
  5.2.11 other elective reconstructive rearfoot/ankle osseous surgery not listed above (i.e.subchondroplasty)

5.2.4 Midfoot, Rearfoot, or Ankle Fusion

- multiple procedures count as one procedure
- Midfoot entails any osseous or soft tissue procedure that is performed proximal to, but not including the tarsometatarsal/Lisfranc joint.

- **EXAMPLE**S: double arthrodesis, triple arthrodesis, pan talar arthrodesis, talonavicular with a calcaneocuboid arthrodesis are all logged as one procedure
  NOTE: 5.2.4 can be claimed in conjunction with 5.2.5, 5.2.7 and 5.2.9 when an osteotomy was done to correct RRA deformity.

5.2.5 Midfoot, Rearfoot or Tibial Osteotomy

- Midfoot entails any osseous or soft tissue procedure that is performed proximal to, but not including the tarsometatarsal/Lisfranc joint.
- **May not** be claimed in conjunction with the following procedures if the osteotomy was performed to access pathology:
  - 5.2.4 midfoot, rearfoot or ankle fusion
  - 5.2.7 open management of talar dome lesion (with or without osteotomy)
  - 5.2.9 ankle implant

NOTE: 5.2.5 can be claimed in conjunction with 5.2.4, 5.2.6, 5.2.7 and 5.2.9 when an osteotomy was done to correct RRA deformity.

May be logged more than once if separate osteotomies are performed to correct a deformity i.e. Evans and Cotton or Evans and medial sliding calcaneal osteotomy

5.2.6 Coalition Resection

- **Cannot be** used if it is done as part of an arthrodesis or arthroeresis procedure
- **May not** be claimed in conjunction with:
  - 5.2.3 subtalar arthroeresis
  - 5.2.4 midfoot, rearfoot, or ankle fusion

- **5.2.4, 5.2.5 may** be claimed when an arthrodesis or osteotomy was done to correct RRA deformity not at the coalition site

5.2.7 Open Management of Talar Dome Lesions (with or without osteotomy)

- **Includes associated:**
  - 5.2.1 operative arthroscopy (does not include STJ arthroscopy)

May not be used in conjunction with
- 5.2.4 midfoot, rearfoot, or ankle fusion (may be used other than with ankle fusion)
- 5.2.5 malleolar osteotomy
- 5.2.8 ankle arthrotomy / arthroscopy with removal of loose body or other osteochondral debridement
- 5.2.9 ankle implant
- 5.2.11 other elective reconstructive rearfoot/ankle osseous surgery not listed above (i.e. subchondroplasty)

5.2.8 Ankle Arthrotomy / Arthroscopy with Removal of Loose Body or Other Osteochondral Debridement

May not be used in conjunction with

5.2.4 midfoot, rearfoot, or ankle fusion (may be used other than with ankle fusion)
5.2.5 malleolar osteotomy
5.2.9 ankle implant
5.2.11 other elective reconstructive rearfoot/ankle osseous surgery not listed above (i.e.subchondroplasty)

5.2.9 Ankle Implant

May not be used in conjunction with

5.1.5 primary or secondary repair of ligamentous structures
5.1.7 open synovectomy of rearfoot / ankle
5.2.1 operative arthroscopy without removal of loose body or other osteochondral debridement
5.2.7 open management of talar dome lesion (with or without osteotomy)
5.2.8 ankle arthrotomy
5.3.2 repair of acute ligament injury
5.4.3 open repair of acute ankle fracture

Non-Elective – Soft Tissue:

5.3.2 Repair of Acute Ligament Injury

- **May not** be used in conjunction with fracture repair or ankle implant

  5.2.9 ankle implant
  5.3.6 open repair of dislocation (proximal to tarsometatarsal joints)
  5.4.1 open repair of adult midfoot fracture
  5.4.2 open repair of adult rearfoot fracture
  5.4.3 open repair of adult ankle fracture
  5.4.4 open repair of pediatric rearfoot/ankle fractures or dislocations

- **Claim** only **one** procedure per foot/ankle even if multiple ligaments are repaired

5.3.4 Excision of Soft Tissue Tumor/mass of the Foot, Ankle or Leg (with reconstructive surgery)

- The harvesting and application of related skin graft/flap count as **one** procedure

5.3.6 Open Repair of Dislocation (proximal to the tarsometatarsal joints)

- **May not** be used in conjunction with fracture repair
  - 5.4.1 open repair of adult midfoot fracture
  - 5.4.2 open repair of adult rearfoot fracture
  - 5.4.3 open repair of adult ankle fracture
  - 5.4.4 open repair of pediatric rearfoot/ankle fractures or dislocations

- **May not** be used in conjunction with
  - 5.3.2 repair of acute ligament injury

- **Claim** only **one** procedure per foot/ankle

Non-Elective – Osseous:

5.4.1 Open Repair of Adult Midfoot Fracture

- **Claim** only **one** procedure per foot

5.4.2 Open Repair of Adult Rearfoot Fracture

- **Claim** only **one** procedure per foot

5.4.3 Open Repair of adult Ankle Fracture

- Repair of ligaments is included in the repair
- Repair of syndesmosis is included in the repair
- Uni/Bi/Tri malleolar fracture repairs are considered one procedure
- **Claim** only **one** procedure per ankle

5.4.4 Open Repair of Pediatric Rearfoot/ankle Fracture or Dislocation

- **Claim** only **one** procedure per foot/ankle

Additional Guidelines

Category 6: Other Podiatric Procedures

6.2 Excision or destruction of skin lesion (i.e. verruca) by any means. Includes biopsy of skin lesion.

6.3 Nail avulsion (partial or complete)

6.4 Matrixectomy (partial or complete, by any means). Use this for procedures performed in the clinic or operating room.

6.5 Removal of hardware. Includes Internal and External Fixation removal.

6.6 Repair of simple laceration / delayed primary closure. Use this for procedures performed in clinic, emergency department or operating room.

6.8 Extracorporeal shock wave therapy

6.9 Taping/ padding/ splinting / casting (limited to the foot and ankle

6.10 Orthotics / prosthetics (limited to the foot and ankle -casting, scanning, impressions for foot and / or ankle orthoses

6.14Percutaneous procedures (i.e., coblation, cryosurgery, radiofrequency ablation, platelet-rich plasma).

6.15 Foot care (nail debridement, callus paring)

6.16 Therapeutic / diagnostic injections (without sedation)

6.17 Incision and drainage (performed outside of the operating room)

6.18 Closed reduction of fracture or dislocation

6.19 Removal of foreign body (not performed in the operating room)

6.20 Acpplication of any type of external fixation device

Category 7: Biomechanical Examinations

A biomechanical case is identified as procedure code 7. 1

- Biomechanical case must include diagnosis, evaluation (biomechanical and gait examination), and treatment.
  - Demonstrates understanding of pathomechanics of biomechanical condition
  -
  - Biomechanical cases should be performed in a variety of settings (surgical and non-surgical) and should include diverse pathology and treatment methods. Biomechanical exams should be a representation of the learning experiences of the residents.

- A biomechanical exam includes static and dynamic exam of the area of chief complaint.

- The biomechanical exam and gait analysis must be comprehensive **relative to the diagnosis** and consistent with the clinical findings.

- Patient encounters such as taping and padding, orthotics, prosthetics, and other biomechanical experiences that do not include a biomechanical examination and gait analysis are not counted as biomechanical cases.

- Gait analysis may range from basic visual gait analysis to complex computerized gait analysis. An interpretation of the gait analysis must be documented.

- Treatment plans must be justified and supported by findings of the biomechanical exam.

Category 8: History and Physical Examinations

8.1 Comprehensive History and Physical Examination:

- Comprehensive medical history: Past medical history, past surgery history, family history, social history, medications, allergies, and review of systems
- Vital signs
- Physical exam: Head, Eyes, Ears, Nose, Throat, Neck, Chest/breast, Lungs, Abdomen, GU, rectal, upper extremity, and neurological
- At least 25 of the 50 required comprehensive H&P's must be performed during non-podiatric rotations under the direction of MD or DO faculty. Comprehensive H&P's must be performed in variety of settings including admission, preoperative, emergency department or during medicine / surgical consultation in the inpatient or outpatient setting. **A focused history and physical examination does not fulfill this requirement.**

8.2 Problem-Focused History and Physical Examination:

- Problem-focused history
- Problem focused exam: vascular, dermatological, neurological, and musculoskeletal exam
- Biomechanical examination
- Gait analysis

Category 11: Lower Extremity Wound Care

11.1 excisional debridement of ulcer or wound (e.g., neuropathic, arterial, traumatic, venous, thermal

11.2 advanced wound care modalities (e.g., negative pressure wound therapy, cellular and/or tissue-based products, total contact casting, multi-layer compression therapy / Unna boot)

11.3 hyperbaric oxygen therapy

Category 13: Other Clinical Experience

13.1 other clinical experiences (i.e. mission trips; procedure performed outside the United States)

ROTATION COMPETENCIES:

1. **Anesthesia**
2. **Behavioral Science**
3. **Emergency Medicine**
4. **Hospitalist/ Internal Medicine**
5. **General Surgery**
6. **Infectious Disease**
7. **Medical Imaging**
8. **Pathology**
9. **Physical Medicine and Rehabilitation (PM&R) / Gait Lab**
10. **Podiatry Service**
11. **Podiatry Surgery**
12. **Rheumatology**
13. **Vascular Surgery**

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1. **Anesthesia Rotation Competencies:**
   - Able to formulate an appropriate plan of management for appropriate anesthetic selection in the surgical patient as part of a preanesthetic evaluation.
   - Can administer local anesthetics with proper technique and utilizing universal precautions.
   - Can recognize and manage adverse reactions to local anesthesia.
   - Assigns proper ASA status.
   - Understands general, spinal epidural, regional and conscious sedation anesthesia and the various chemical agents and their dosages used in those procedures.
2. **Behavioral Science Rotation Competencies:**
   - Has the capacity to manage individuals and populations in a variety of socioeconomic and healthcare settings.
   - Demonstrates sensitivity and responsiveness to cultural values, behaviors and preferences of their patients when providing care to persons whose race ethnicity, nation of origin, religion, gender or sexual orientation.
   - Demonstrates understanding of public health concepts, health promotion and disease prevention.
   - Advocates for quality patient care and assists patients in dealing with system complexities.
3. **Emergency Medicine Rotation Competencies:**
   - Can perform a problem focused history and physical examination.
   - Can correlate and interpret laboratory and diagnostic testing associated with a specific diagnosis.
   - Demonstrates caring and respectful behavior when interacting with patients.

- Able to determine the appropriate consultant and discuss the patient's condition with same.
- Can implement an appropriate plan of management for closed fractures and dislocations.
- Can perform appropriate medical/surgical management of repairing a simple laceration.
- Recognizes and diagnose common infectious processes.
- Able to evaluate and classify traumatic injuries for proper treatment and referral.

4. **Hospitalist/ Internal Medicine Rotation Competencies (PGY1):**
   - Perform and interpret the findings of a comprehensive medical history and physical examination, including:
     - Comprehensive medical history including chief complaint, review of systems, history of present illness, social and family history
     - Comprehensive physical examination including vital signs HEENT, neck, chest/breast, heart, lungs, abdomen, GU, rectal, extremities, and neurologic examination
   - Order and interpret appropriate laboratory tests, based on presenting medical history and clinical findings.
   - Pharmacologic management of patients including the proper ordering of medications, being fully cognitive of indications, dosages, interactions, side effects, and anticipated results.
   - Recognize the need for, and the appropriate ordering and interpretation of additional diagnostic studies including EKGs, medical imaging, vascular studies and laboratory studies.
   - Interpret and evaluate EKGs.
   - Utilize information obtained from the history and physical examination and ancillary studies, after appropriate investigation, observation, and judgement, to arrive at an appropriate differential diagnosis and treatment plan.

5. **General Surgery Rotation Competencies:**
   - Can perform and interpret the findings of a comprehensive history and physical examination.
   - Understands basic general surgical principles.
   - Understands management of preoperative and postoperative patients and complications.
   - Understands wound healing principles.
   - Shows proficiency with various suturing techniques.
   - Has familiarity with prophylaxis.

6. **Infectious Disease Rotation Competencies:**
   - Can perform and interpret the findings of a comprehensive medical history and physical examination
   - Can formulate an appropriate differential diagnosis of the patient's general medical problems.
   - Can recognize the need for and / or orders diagnostic studies when indicated.
   - Understands when to order appropriate imaging studies such as plain radiographs, nuclear imaging, and MRI
   - Understands when to order appropriate laboratory tests such as hematology, serology, chemistries, toxicology, coagulation studies, blood gases, microbiology, synovial fluid analysis, and urinalysis.
   - Can formulate an appropriate plan of management including therapeutic intervention, appropriate consultations and referrals.
   - Can recognize and diagnose common infectious processes.

- Can select appropriate antibiotic therapy.
- Can use results of diagnostic testing to monitor and evaluate treatment.

7. **Medical Imaging Rotation Competencies:**
   - Can perform and/or interpret diagnostic studies including plain radiographs, contrast studies, stress radiographs, fluoroscopy, nuclear medicine imaging, MRI, CT, diagnostic ultrasound, and vascular imaging.
   - Can read a radiographic study in a logical and orderly manner.
   - Can recognize normal and abnormal findings within a radiographic study.
   - Recognizes when additional studies may be necessary to diagnose a patients condition.

8. **Pathology Rotation Competencies:**
   - Can perform and/or interpret appropriate diagnostic tests including hematology, serology, blood chemistries, microbiology, and synovial fluid analysis.
   - Recognizes normal and abnormal test values.
   - Understands the proper technique for procuring pathology specimens.
   - Understands how cellular tissue samples are transported to the lab and how they are prepared.
   - Recognizes the normal and abnormal microscopic features of the specimen.
   - Understands anatomic pathology.

9. **Physical Medicine and Rehabilitation (PM&R) Rotation Competencies:**
   - Understands the prevention, diagnosis and management of diseases disorders and injuries of the pediatric and adult lower extremities by nonsurgical means utilizing educational, medical, physical and biomechanical means.
   - Can perform and interpret the findings of a thorough problem focused history and physical exam.
   - Can perform and /or order and interpret appropriate diagnostic testing such as , medical imaging, electrodiagnostic studies, computerized gait/ force plate studies.
   - Can formulate an appropriate diagnosis and differential diagnosis based on history and physical exam and diagnostic studies.
   - Can formulate an appropriate treatment plan and revise it as necessary.

10. **Podiatry Service Rotation Competencies:**
    - Can prevent, diagnose, and manage diseases, disorders, and injuries of the pediatric and adult lower extremities, by nonsurgical and surgical means.
    - Can manage a podiatric practice with a diverse patient population in a variety of socioeconomic and health care settings.
    - Understands health care reimbursement and common business practices. In the practice of podiatric medicine.
    - Can perform a problem focused history and physical examination on a child or adult patient.
    - Able to develop a differential diagnosis, and diagnosis by correlating a focused history and physical examination and objective diagnostic test results, in the development of a management plan for that patient's diagnosis.
    - Can order appropriate imaging and laboratory studies to develop a working diagnosis.
    - Demonstrates a caring and respectful behavior when interacting with patients.
    - Can communicate with consultants when discussing pertinent aspects of a patient's condition.

- Understands the management of preoperative and postoperative surgical patients with emphasis on complications.
- Can perform a complete biomechanical examination.
- Can cast both feet in prone and supine position, with subtalar joint neutral position as well as take semi weight bearing foam impressions for molded shoes and custom molded foot orthoses.
- Can manage common lower extremity complaints such as, heel pain, diabetic complications, fractures, and skin and nail problems in a clinic setting.
- Can perform local anesthetic blocks in order to perform office procedures such as ingrown toenail corrections and skin biopsies.
- Understands the principles of informed consent in the clinic setting.
- Has the capacity to manage individuals and populations in a variety of socioeconomic and health care settings.
- Advocates for quality patient care and demonstrates understanding of Public health concepts, health promotion and disease prevention.
- Understands healthcare reimbursement and common business practices including coding and billing practices, insurance issues regarding podiatric practice, and marketing a practice to other healthcare practitioners and residents.
- Can perform a problem focused history and physical examination to develop a differential diagnosis list.
- Can manage a patient's diagnosis by performing and/or ordering the appropriate diagnostic and laboratory testing, and able to prescribe the appropriate medications when indicated.
- Can properly manage a diabetic patient with appropriate pedal vascular, and neurological examination, scheduling for fitting of proper footwear and providing education and routine palliative care when indicated.
- Can perform a noninvasive vascular examination including Doppler and ABI studies.
- Orders appropriate ancillary therapeutic services including but not limited to physical and occupational therapy, wound care, pain management, psychosocial services, and orthotics and prosthetics.
- Understands the podiatrist's role in a nursing home and physically and mentally handicapped outpatient facility.
- Can perform a biomechanical examination and casting for custom molded foot orthoses.
- Can diagnose and treat simple fractures and dislocations conservatively.
- Can perform local anesthetic blocks and perform common podiatric procedures in the office setting such as nail avulsions, biopsies of skin lesions and permanent nail excisions.
- Understands the concept of offloading with molded shoes, felt padding and adhesive tape strappings in the conservative management of painful foot deformities.
- Understands the role of Durable Medical Equipment in the podiatrist's office.
- Identify and treat ulcerations as they relate to the foot, ankle, and lower extremity
- Generate appropriate differential diagnoses for ulcerations (arterial, venous, pressure, traumatic)
- Understand underlying causes of ulceration as they related to biomechanics of the foot
- Demonstrate understanding in appropriate forms of debridement (sharp, enzymatic, mechanical)
- Understand treatment options for wounds (hydrogels, hydrocolloids, films, foams, skin equivalents, skin grafts, flaps, etc.)
- Understand classification systems for wounds and how they related to treatment
- Generate treatment plans for wounds (conservative vs. surgical)

11. Podiatry Surgery Rotation Competencies:

- Can perform a problem focused history and physical examination of the lower extremity.
- Can perform and/or order and interpret appropriate diagnostic tests such as medical imaging, laboratory tests, pathology, and diagnostic studies.
- Can formulate a differential diagnosis and make a diagnosis based on objective findings.
- Can develop and implement a management plan for a patient's diagnosis.
- Can plan and carry out a surgical management plan for a patient with a defect in skin structure such as, biopsy, nail avulsion, matricectomy,repair of simple laceration, and excision of skin wedge.
- Has the understanding of basic fixation principles and knows the proper use of basic fixation hardware.
- Can perform digital surgical procedures understanding patient positioning, anesthesia choices, hemostasis choices, proper skin incision placement, proper anatomic dissection, tissue handling, utilizing proper instrumentation manual and power, proper wound closure and suture choices, proper bandaging and discharge instructions.
- Can perform first ray surgery understanding all of the above principles as well as applying fixation devices, applying wound drainage systems, handling bioimplants and tissue grafts, and can recognize preoperative, intraoperative, and postoperative variations or complications and adapts accordingly.
- Can perform other soft tissue surgery understanding all of the above principles as well as the special handling of tendons and instrumentation associated with transfers, can perform complicated wound debridement techniques, can prepare tissue samples for pathologic examination and perform plastic surgical skin repair for skin plasties, skin flaps, syndactylizations and desyndactylizations.
- Can perform other osseous surgery understanding all of the above principles as well as preparing the patient by presenting the procedure in detail including the risks and alternatives and postoperative recovery.
- Practices and abides by the principles of informed consent.
- Demonstrates the ability to communicate effectively and function in a multidisciplinary setting.
- Has the ability to manage individuals and populations in a variety of socioeconomic and healthcare settings.
- Can assess and manage the patient's general medical status.
- Can formulate and implement a plan of management of patients with lower extremity fractures and dislocations.
- Understands the management of preoperative and postoperative foot and ankle surgical patients with emphasis on complications.
- Can manage lower extremity trauma including sedation and anesthesia, and reduction of fractures,
- Can utilize various casting, splinting and immobilization techniques.
- Can classify trauma injuries of the lower extremities after radiologic and physical evaluation.
- Understands open and closed fracture reduction and AO internal fixation principles.
- Understands various fixation hardware and their designed use.
- Actively participates in foot and ankle trauma and reconstructive surgical cases as well as rounds on foot and ankle orthopedic cases.

12. Rheumatology Rotation Competencies:

- Can perform and interpret the findings of a comprehensive medical history and physical examination.
- Formulate an appropriate differential diagnosis of the patient's medical problem by recognizing the need for diagnostic studies when indicated.
- Ordering and/or performing diagnostic procedures such as , EKG, imaging, laboratory tests, and synovial fluid analysis.
- Creating and implementing a plan of management including therapeutic intervention, consultations, and medical health promotion and education.
- Understand prescription medication and infusions role in treating various rheumatologic disorders.

13. Vascular Surgery Rotation Competencies:

- Can perform a problem focused history and physical examination with emphasis on vascular disease.
- Can perform a noninvasive vascular examination and understands the normal and abnormal findings associated with it.
- Can evaluate the vascular wound and able to stage and treat with the appropriate diagnostic testing and surgical intervention.
- Understands the principles of Hyperbaric oxygen and its role in wound healing.
- Assists in the surgical management of patients having skin grafts, bypass surgery, stent insertion and endothelial procedures, and amputations

Links to CPME 320 and CPME 330:

CPME 320

CPME 330: https://www.cpme.org/residencies/on-site-evaluation-of-approved-residency-programs/

PRE-OP ORDERS:

Dr. Malik:

- ALWAYS pre-op antibiotic Ancef lg if weight<70kg, if >70kg give 2g pre-op, if allergic to PCN, then use clindamycin

Depart Instructions:

- For easy ST masses or toe arthroplasties use just riaproxen 500mg #20 tabs, 1tab po bid
  - For osteotomies: Tramadol 50mg #20tabs 1 tab po q6hrs pm severe pain
  - if the patient is SUPER feisty about tramadol, then Percocet 5/325 #20tabs 1tab po q6hrs pm severe pain

- Out of bed with assist
- Custom Dr. Rettig in depart instructions.
- F/up in 1 week in the office for wound check. Surgery:
- ❍ Dr Rettig brings Xrays with him, ask and put on display.
- Block- 0.5% Marc.aine plain in 3cc syringes for pre-op block, have DECADRON and Tb syringe on a field for post-op pain management.
- Scrubbing: Nurse scrubs the foot with hibiclens scrub. We prep! Use 1L saline bottle under the ankle.
- Osteotomy (long plantar arm always), screw running from proximal dorsal to distal plantar.
- Skin closure always running interlocking for everything. The capsule always running, 2 subq buried knot sutures closure.
- Dressings: adaptic, DSD 4x4 gauze don't unfold, kling, ace wrap. No betadine! Remember about decadron.
- Weight bearing: surgical shoe with crutches for McBride and Keller bunions, implants. For toe surgeries: NO CRUTCHES! Just surgical shoe for hammertoes, soft tissues. Bunions with screw

o Put in orders heel weight bearing with crutches.

EMCM PRE-OP ORDERS

Dr Pagano:

❍ Always pre-op antibiotic Ancef lg if weight<70kg, if >70kg give 2g pre-op, if allergic to PCN, then use clindamycin

Depart Instructions:

o Post op meds Percocet 5/325 (usually 40) and any time there is an implant or screw Keflex 500 mg TID 7 days

❍ No custom depart, fill in blanks

- Patient given custom depart information from their office

Surgery:

❍ Scrubbing: nurses do betadine scrub.

- Preop Block- 1:1 mix of 2% Lidocaine plain and 0.5%Marcaine plain
- Skin closure- Closure buried knot subcutaneous closure, 5-0 monocryl subcuticular skin closure with mastisol and steristrips.
- Dressings; xeroforrn, betadine soaked 4x4 gauze, kling, acewrap.

❍ Weight bearing: surgical shoe with crutches for distal osteotomy bunions, hammertoes, soft tissues. Put in orders heel weight bearing with crutches. For proximal metatarsal osteotomies, fusions, TALs- 8K cast or posterior splint

- F/up included in depart information they provide the patient, usually one week.

Dr Varghese:

* Always pre-op antibiotic Ancef ig if weight<70kg, if >70kg give 2g pre-op, if allergic to PCN, then use clindamycin

Depart Instructions:

❍ Post op meds Percocet 5/325 (usually 40) and any time there is an implant or screw Keflex 500 mg ¯nD 7 days

❍ No custom depart, fill in blanks

- Patient given custom depart information from their office

Surgery:

❍ Scrubbing: nurses do betadine scrub.

❍ Preop Block- 1:1 mix of 2% Lidocaine plain and 0.5%Marcaine plain

- ❍ Skin dosure- Closure buried knot subcutaneous dosure, 5-0 monocryl subcuticular skin closure with mastisol and steristrips.
- Dressings: xeroform, betadine soaked 4x4 gauze, kling, acewrap.
- Weight bearing; surgical shoe with crutches for distal osteotomy bunions, hammertoes, soft tissues. Put in orders heel weight bearing with crutches. For proximal metatarsal osteotomies, fusions, TALs- BK cast.

o F/up included in depart information they provide the patient, usually oneweek.

Human Resources

ONLINE Access – ONE Intranet

ONE is the enterprise-wide intranet for all Jefferson colleagues.

- Go to One.Jefferson.edu.
- Click on **Employee Resources** at the top of the ONE home page.
- Navigate to the **Working at Jefferson** workspace to find benefit details.

Set Up the ONE (Unily) Mobile App

1. Download **Unily Mobile** from your device's app store.
2. Enter the six-digit client code: **301469**
3. Log in using your **Campus Key** and **password**

Accessing Workday via ONE

Through the website, you can access **Workday** to:

- View your current benefits
- Enroll in benefits
- Select and update your beneficiary designation
- View your pay stub
- Review and update your address and phone number

Your Campus Key and Password

New colleagues can contact **IS&T** at **215-955-7975** to obtain their Campus Key and password.

HR Service Center

If you can't find an answer to your question on ONE:

- Call the **HR Service Center** at **215-503-4772** (select **Option 8**)
- Or submit your question online at bit.ly/JeffersonHRSC

The HR Service Center can help with:

- Benefits
- Policies
- Workday
- General payroll issues

JEFFERSON HEALTH — JEFFERSON EINSTEIN PHILADELPHIA HOSPITAL
Benefits Summary for EMCP Residents
Plan Year: July 1, 2025 – June 30, 2026

Jefferson's flexible benefits program allows you to select benefits based on your needs. All regular full-time employees (working 32+ hours/week) and regular part-time employees (20+ hours/week) are eligible. Enrollment must be completed online within 30 days of hire or transfer.

HEALTH INSURANCE

Eligibility: Full-time | **Start:** Date of Hire

Plan Options:

- Jefferson First PPO
- Jefferson Select PPO
- Jefferson Choice PPO
- Jefferson HDHP + HAS

Jefferson First PPO

- New type of medical plan that offers comprehensive care at the lowest cost for colleagues.
- While the other plans also feature four networks of providers, this plan has no deductible, coinsurance or copayment for all services (except emergency room visits) received at a Jefferson provider, including LVHN.
- Colleagues who are not benefits-eligible will have the ability to enroll in the Jefferson First plan.

Benefit Summary

- Jefferson First PPO Medical Plan Summary

Jefferson Select PPO

- This plan has a lower employee contribution than Jefferson Choice, giving you a more affordable option if you're not interested in the Jefferson First or Jefferson HDHP + HSA options.
- This plan includes both Jefferson and Affiliates Networks in the first network — just like your medical options today.

Benefit Summary

- Jefferson Select PPO Medical Plan Summary

Jefferson Choice PPO

- This plan has the highest contribution for colleagues.
- The plan includes both Jefferson and Affiliates Networks in the first network — just like your medical options today.
- Jefferson Choice offers the highest level of benefits in Independence Administrators network compared to the other options.
- This is the only option that includes coverage for fertility and hearing aids.

Benefit Summary

- Jefferson Choice PPO Medical Plan Summary

Jefferson HDHP + HSA

- This plan is a qualified high-deductible health plan (HDHP) that comes with a Health Savings Account (HSA) administered by WEX.
- It has the same provider networks as the Jefferson Select and Jefferson Choice plans.
- Jefferson will contribute to your HSA — and you can also make your own pre-tax contributions.
- In this plan, your medical and prescription deductible is combined. Once your deductible is met, regular medical and prescription cost shares will apply.
- This plan has different coverage for Specialty Medications.

SUPPLIMENTAL INSURANCE

Eligibility: Full-time | **Start:** 1st of month after hire

- Offered through Lincoln Financial Group
- Options: **Accident**, **Critical Illness**, **Hospital Indemnity**

PRESCRIPTION

Prescription coverage will continue with CVS Caremark, and you'll continue to save money when you fill non-maintenance prescriptions at a Jefferson-owned pharmacy rather than a retail pharmacy. Whether there are any changes to your prescription drug benefits depends on the medical plan you choose:

- If you enroll in the Jefferson First, Jefferson Select or Jefferson Choice Plans, you will not see any changes in your prescription drug coverage.
- If you enroll in the Jefferson HDHP + HSA, there are a few differences in how your prescription drug benefits will work.
    - First, your medical and prescription deductible will be combined. Once your deductible is met, the regular prescription cost share will apply.
    - Second, the $0 copay PrudentRx Copay Program will not be available for Specialty Medications. You will pay 30% after meeting your deductible. (not available in the HDHP +HAS)

COST CONSIDERATIONS

Save With the Wellness Credit

Eligible employees who are enrolled in a Jefferson medical plan can participate in the Wellness Credit program to receive **$15 each pay period** after completing program requirements.

Learn About the Wellness Credit

Tobacco/Nicotine Premium

If you are enrolled in the medical plan and attest during open enrollment to you or your spouse using tobacco or nicotine products, you will be charged a **$35 per pay period** premium.

Report a Change in Tobacco/Nicotine Usage

Spousal Medical Coverage Charge

If your spouse has coverage available through another employer and you choose to cover your spouse under a Jefferson medical plan, you will pay an additional **$75 per pay period** premium.

DENTAL INSURANCE
Delta Dental of Pennsylvania

Platinum Preferred Provider Organization (PPO)

- Highest employee contributions
- Go to any licensed dentist
- No primary care dentist (PCD) needed
- Lower out-of-pocket costs when you stay in-network
- No referrals required
- Deductibles and plan year dollar limits
- Orthodontia is covered

Gold Preferred Provider Organization (PPO)

- Mid-range employee contributions
- Go to any licensed dentist
- No primary care dentist (PCD) needed
- Lower out-of-pocket costs when you stay in network
- No referrals required
- Deductibles and plan year dollar limits
- Orthodontia is not covered

Dental Maintenance Organization (DMO)

- Lowest employee contributions
- In-network primary care dentist (PCD) required and must use providers in the network
- Referrals required for specialty care (except orthodontia)
- No deductibles or plan year limits
- Orthodontia is covered

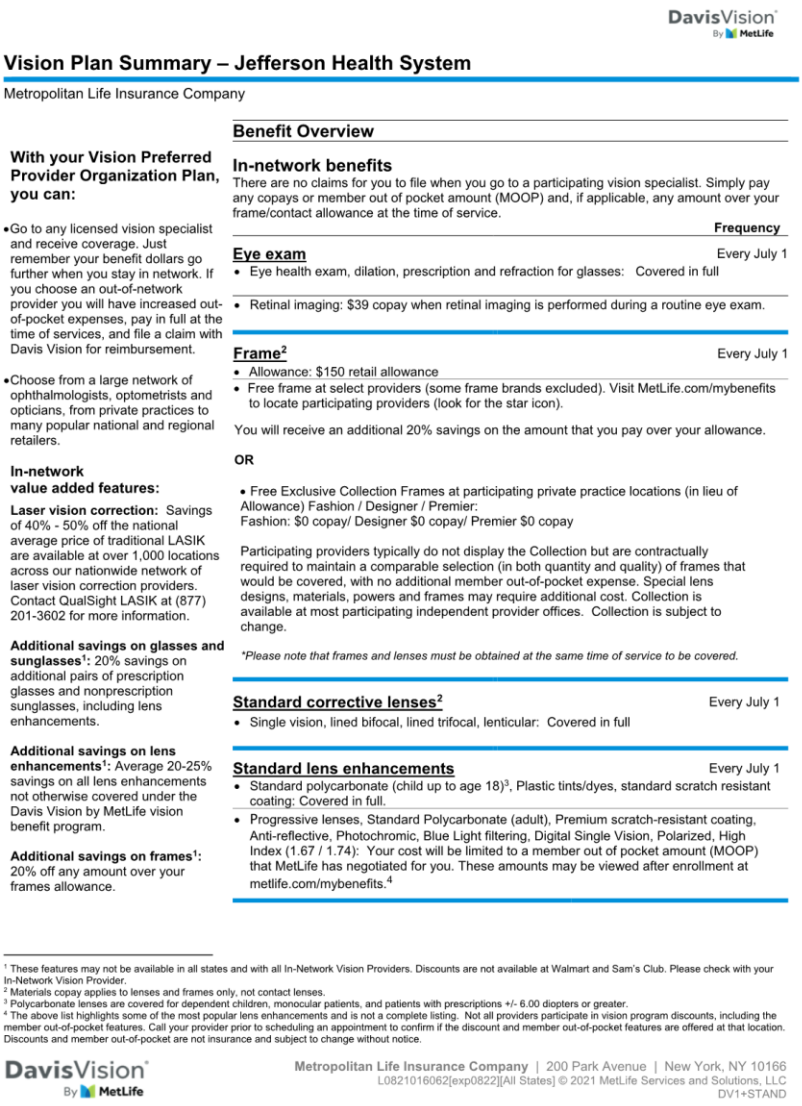
DAVIS VISION

In-Network Coverage Info

When you use a Davis Vision participating provider, you'll maximize your benefit dollars. Locate a participating provider online or call 833-393-5433. Check out the Vision Plan Summary for details.

Out-of-Network Coverage Info

If you choose an out-of-network provider, you must pay the provider directly for all charges and then submit a claim for reimbursement. Check out the Vision Plan Summary for details.



DavisVision By MetLife

Vision Plan Summary – Jefferson Health System

Metropolitan Life Insurance Company

With your Vision Preferred Provider Organization Plan, you can:

- Go to any licensed vision specialist and receive coverage. Just remember your benefit dollars go further when you stay in network. If you choose an out-of-network provider you will have increased out-of-pocket expenses, pay in full at the time of services, and file a claim with Davis Vision for reimbursement.
- Choose from a large network of ophthalmologists, optometrists and opticians, from private practices to many popular national and regional retailers.

In-network value added features:

Laser vision correction: Savings of 40% - 50% off the national average price of traditional LASIK are available at over 1,000 locations across our nationwide network of laser vision correction providers. Contact QualSight LASIK at (877) 201-3602 for more information.

Additional savings on glasses and sunglasses[1]: 20% savings on additional pairs of prescription glasses and nonprescription sunglasses, including lens enhancements.

Additional savings on lens enhancements[1]: Average 20-25% savings on all lens enhancements not otherwise covered under the Davis Vision by MetLife vision benefit program.

Additional savings on frames[1]: 20% off any amount over your frames allowance.

Benefit Overview

In-network benefits

There are no claims for you to file when you go to a participating vision specialist. Simply pay any copays or member out of pocket amount (MOOP) and, if applicable, any amount over your frame/contact allowance at the time of service.

	Frequency
Eye exam	Every July 1
• Eye health exam, dilation, prescription and refraction for glasses: Covered in full	
• Retinal imaging: $39 copay when retinal imaging is performed during a routine eye exam.	
Frame[2]	Every July 1
• Allowance: $150 retail allowance	
• Free frame at select providers (some frame brands excluded). Visit MetLife.com/mybenefits to locate participating providers (look for the star icon).	
You will receive an additional 20% savings on the amount that you pay over your allowance.	
OR	
• Free Exclusive Collection Frames at participating private practice locations (in lieu of Allowance) Fashion / Designer / Premier: Fashion: $0 copay/ Designer $0 copay/ Premier $0 copay	
Participating providers typically do not display the Collection but are contractually required to maintain a comparable selection (in both quantity and quality) of frames that would be covered, with no additional member out-of-pocket expense. Special lens designs, materials, powers and frames may require additional cost. Collection is available at most participating independent provider offices. Collection is subject to change.	
**Please note that frames and lenses must be obtained at the same time of service to be covered.*	
Standard corrective lenses[2]	Every July 1
• Single vision, lined bifocal, lined trifocal, lenticular: Covered in full	
Standard lens enhancements	Every July 1
• Standard polycarbonate (child up to age 18)[3], Plastic tints/dyes, standard scratch resistant coating: Covered in full.	
• Progressive lenses, Standard Polycarbonate (adult), Premium scratch-resistant coating, Anti-reflective, Photochromic, Blue Light filtering, Digital Single Vision, Polarized, High Index (1.67 / 1.74): Your cost will be limited to a member out of pocket amount (MOOP) that MetLife has negotiated for you. These amounts may be viewed after enrollment at metlife.com/mybenefits.[4]	

[1] These features may not be available in all states and with all In-Network Vision Providers. Discounts are not available at Walmart and Sam's Club. Please check with your In-Network Vision Provider.
[2] Materials copay applies to lenses and frames only, not contact lenses.
[3] Polycarbonate lenses are covered for dependent children, monocular patients, and patients with prescriptions +/- 6.00 diopters or greater.
[4] The above list highlights some of the most popular lens enhancements and is not a complete listing. Not all providers participate in vision program discounts, including the member out-of-pocket features. Call your provider prior to scheduling an appointment to confirm if the discount and member out-of-pocket features are offered at that location. Discounts and member out-of-pocket are not insurance and subject to change without notice.

DavisVision By MetLife

Metropolitan Life Insurance Company | 200 Park Avenue | New York, NY 10166

DV1+STAND

FLEXIBLE SPENDING ACCOUNTS (FSA)

Medical Spending Account

- Can use pre-tax dollars for medical expenses not covered by your health, dental and vision plans
- This year's maximum is $3,050.
- Plan is through WEX www.wexinc.com
- Use it or lose it – any funds not used by the deadline are forfeited. Rules for FSA's are governed by the IRS

DEPENDENT CARE FSA

- Estimated dependent care expenses for children under age 13 can be deducted before taxes from your paycheck and diverted into this account to a maximum of $5,000 per plan year if both parents work
    - Can be used for things like daycare, after-school programs, nursery school or preschool, summer day camp, care in your home, housekeeper who performs dependent care duties and/or taxes paid toward a caregiver's wages (providers of these services must report income)
- If your income is $130,000 or more, your contribution to this account may be reduced due to IRS rules

-

HSA

Medical Spending Account

- Can use pre-tax dollars for medical expenses not covered by your health, dental and vision plans
- This year's maximum is $3,050.
- Plan is through WEX www.wexinc.com
- Use it or lose it – any funds not used by the deadline are forfeited. Rules for FSA's are governed by the IRS

DEPENDENT CARE FSA

- Estimated dependent care expenses for children under age 13 can be deducted before taxes from your paycheck and diverted into this account to a maximum of $5,000 per plan year if both parents work
    - Can be used for things like daycare, after-school programs, nursery school or preschool, summer day camp, care in your home, housekeeper who performs dependent care duties and/or taxes paid toward a caregiver's wages (providers of these services must report income)
- If your income is $130,000 or more, your contribution to this account may be reduced due to IRS rules

RETIREMENT PROGRAMS

403(b) RETIREMENT SAVINGS PLAN

- Auto enrollment: Newly hired physicians will be automatically enrolled to contribute 3% into the plan within 45 days from date of hire
- Voluntary contributions on a before or after-tax basis to an annual maximum of $19,500 ($26,000 if age 50+)
    - Roth contributions are deducted after federal income taxes are paid and distribution is tax free if the money is held in the account for 5 years. No loans or hardship withdrawals can be made again the Roth 403(b) account
- Wide choice of high-quality mutual funds through Fidelity Investments
- Einstein adds a 20% match, up to 4% of pay, with an annual maximum match of $400. To receive the match, you must work at least 1,000 hours during the calendar year, and be employed by Einstein on December 31 each year and earn less than $100,000 for the year. The match is determined and deposited annually, during the first quarter of the following calendar year
- To make changes and/or to opt out, you must contact Fidelity directly at 800-343-0860 or visit their website; netbenefits.com
- 100% vested and portable
- For additional pension questions, contact Amira Adams at AdamsAmi@einstein.edu

PROFESSIONAL LIABILITY INSURANCE

- Provided under the self-insurance program of EHN in accordance with Commonwealth of PA requirements
- Current coverage rates are:
    - $500,000 per occurrence
    - $1,500,000 per annual aggregate
- Coverage thereafter will be provided by the Medical Professional Liability Catastrophe Loss Fund (CAT Fund) in the amount of:
    - $700,000 per occurrence
    - $2,100,000 annual aggregate

BASIC LIFE INSURANCE

- Residents receive coverage for one times base pay to a maximum of $20,000

VOLUNTARY LIFE AND DEPENDENT LIFE INSURANCE

- Offered by MetLife
- Guaranteed issue (no medical evidence) to lesser than 3x base pay. You may apply for amounts above guaranteed issue limit with evidence of insurability
- Must apply within 90 days from date of hire to qualify for guaranteed issue
- Employee-paid benefit through payroll deduction
- Can sign up for supplemental policies at mybenefits.metlife.com
- Dependent Life:
    - Spouse or domestic partner eligible for life benefit in increments of $10,000
        - If under age 65, first $20,000 is guaranteed
        - Must apply within 90 days from date of hire of spouse
        - Maximum benefit of $150,000
        - Includes waiver of premium, AD&D and Accidental Death Benefit Policy is portable at group rates
    - Children 14 days to age 23 eligible for $5,000 or $10,000 term guaranteed dependents
    - Children age 14 days to 6 months are provided 10% of coverage
    - Only one parent may cover child if both are employed at Einstein
    - Includes waiver of premium, AD&D, Accidental Death Benefit and is portable

PAID TIME OFF (PTO)

- You will receive 160 hours per year – scheduled by department
- Time is use it or lose it, and any unused PTO time is not be paid out upon termination

SICK LEAVE

- Earn 12 days per year to a maximum of 180 days
- Time can be used during the three-month waiting period for long-term disability
- Time is not paid out at termination

LONG-TERM DISABILITY

- Plan pays after 180 days of continuous disability for non-work-related illness or injury
- 60% of base salary to maximum of $2,500/month minus any other group disability benefits and/or Social Security
- If totally disabled, benefits extend to age 65
- Convertible to individual policy at a discounted rate

VOLUNTARY SHORT-TERM DISABILITY

- You may elect a plan that pays 60% or 40% of your base pay (up to $6,000)
- Benefits begin after you are absent 14 calendar days
- You must use 14 days accrued sick time before Short-Term Disability may begin
- Age and salary-based premium paid through payroll deduction

OTHER BENEFITS (wellbeing)

CAREBRIDGE: Einstein's Employee Assistance Provider (EAP) is available to you and your family members 24/7/365. Carebridge provides services and support for the common – and uncommon – personal and family challenges of life. These confidential services are provided at no cost to you or your family members and are just a click or phone call away (800-437-0911).

TUITION REIMBURSEMENT

ADOPTION BENEFIT

VERIZION AND AT&T WIRELESS DISCOUNT: Receive up to 22% off eligible service plans, accessories, and more. Visit EinsteinConnect and click Working at Einstein, then Discounts for more information

ADDITIONAL VOLUNTARY BENEFITS FROM METLIFE:

- **ACCIDENT INSURANCE BENEFIT:** Lump sum payment paid to employee for over 150 covered accidents (fractures, dislocations, and medical treatments or tests) to help cover unexpected costs associated with an accident
- **HOSPITAL INDEMNITY INSURANCE:** Lump sum payment paid to employee for hospitalization to help cover unexpected costs resulting from a hospitalization
- **CRITICAL ILLNESS INSURANCE:** Lump sum payment paid to employee to help pay for unexpected costs associated with a diagnosis of a critical illness such as cancer, heart attack, stroke, and kidney failure

LEGAL SERVICES

IDENTITY THEFT

FREEDOM CREDIT UNION & ARDENT CREDIT UNION: The credit unions offers employees a wide variety of financial services at favorable rates

NUTRITION COUNSELING:

AUTO AND HOMEOWNERS INSURANCE

AXA LOAN FORGIVENESS: By working for a non-profit hospital, like Jefferson Einstein, you may be eligible for one or more loan forgiveness programs that can help you lower your monthly payment and pay off your student loans more quickly. AXA understands the need to help eliminate student debt and now offers tools and resources that can help you take advantage of the federal student loan forgiveness program. You must apply and re-certify every year of qualified employment to get Public Service Loan Forgiveness. You must also work full-time for a qualifying employer, be on an income-driven repayment plan, make 120 qualifying payments, and your loans must be direct loans (not private loans). Learn more by calling AXA Advisors, LLC at 610-660-4417 or visit EHNloanforgiveness.com

ADDITIONAL INFORMATION

The full Benefits Guide can be found at Benefits Guidebook: 2025-2026

https://one.jefferson.edu/sites/employee-resources

NEW INNOVATIONS: https://www.new-innov.com/Login/Home.aspx

Sign into your account:
Password reset through your Program Coordinator. (Katrina Straube)

Home Page:
Links to all Well-being Documents
Policies including
Code of Conduct,
Resident Leave of Absence,
Transition of care,
Wellbeing, Social Media,
Grievances,
Personal Leave,
Clinical and Educational Work Hours

Please note this summary is provided for informational purposes only. Official plan documents govern actual benefits and are subject to change.