

DISCHARGE SUMMARY

CHILDRENS HOSPITAL OF LOS ANGELES

PATIENT NAME: CONSERVA, Max
ADMITTED: 08/04/89
ATTEND. PHYSICIAN: Dr. Tolo

UNIT NUMBER: 96 20 54
DISCHARGED: 08/24/89
FLOOR:

ADMISSION DIAGNOSIS: Degloving injury to the right lower extremity with a right peroneal motor palsy.

PRINCIPAL DIAGNOSIS: Degloving injury to the right lower extremity with a right peroneal motor palsy.

ADDITIONAL DIAGNOSIS:

COMPLICATIONS, HOSPITAL INFECTIONS, DRUG REACTIONS: None.

PROCEDURES/OPERATIONS:

HISTORY OF PRESENT ILLNESS: This is an 8-year-old male who was admitted to Simi Valley Hospital on August 1, 1989, with a degloving injury to the right lower extremity secondary to a large truck running him over and dragging him along the road. The patient lost the whole lateral aspect of the distal femur, proximal tibia and had a peroneal nerve palsy. The patient basically had degloving injury from the proximal portion of the lateral aspect of the thigh all the way to the midportion of the leg.

The patient went to the Operating Room at Simi Valley Hospital where he underwent irrigation and debridement and placement of two Steinmann pins for fixation of the knee and closure of wounds over the drains.

The patient was then transferred here to Childrens Hospital of Los Angeles for further followup treatment and evaluation.

HOSPITAL COURSE: On 08/04/89 the patient was admitted to Childrens Hospital of Los Angeles where he underwent evaluation. Plastic Surgery saw the patient and felt that he should be taken to the Operating Room to undergo irrigation and debridement and skin grafting of the wound. The patient was thus taken to the Operating Room on 08/05/89 where he underwent irrigation and debridement of the right lower extremity and split thickness skin graft to the right lower extremity. The patient tolerated the procedure well and was then transferred to the ward in stable condition.

The patient continued to do well over the next several days and was maintained in his dressings and splint without any intervention. His temperature remained low throughout the course of the wound therapy. The patient was then taken to the whirlpool where he had the dressings taken down on 08/14/89. At that time Plas-

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tic Surgery felt the patient had a 100% take of the graft but would require further hydrotherapy. The patient was then fitted for a brace in the right lower extremity.

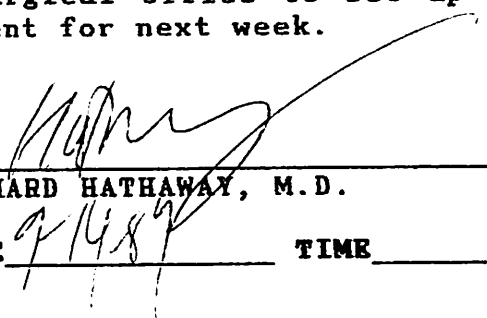
The patient maintained whirlpool therapy and did quite well but it was felt that he would need further surgical intervention. He was thus taken to the Operating Room on 08/22/89 where he had pin removal of the right lower extremity and was examined under general anesthesia. At that time we found that the medial collateral ligament, anterior cruciate ligament, posterior cruciate ligament were all intact. It was difficult to examine the meniscus secondary to the patient being asleep. The leg appeared to have some stability on varus stress of the knee but it is unclear what is maintaining the stability. Range of Motion at that time was 0-125 degrees. The patient also underwent debridement of the burns and application of split thickness skin graft to the right thigh to the lateral aspect of the thigh. This was done by General Surgery. The patient continued to do well and was taught by physical therapy how to ambulate and gait train. He was placed in a CPM postoperatively from 0-80 degrees and was advanced up to 0-90 degrees. The patient tolerated the procedure well. The brace fit well and he was discharged home in stable condition after clearing physical therapy.

FUTURE CARE & FOLLOWUP:

The patient will be followed up in Dr. Tolo's clinic on September 6, 1989.

DISCHARGE MEDICATIONS:

Tylenol Elixir, 10 ml., p.o., q. 4-6 hours, p.r.n. pain. To be noted the patient will also be seen by Psychiatry as an outpatient. The patient should call the Plastic Surgical office to set up appointment for next week.



M.D.
RICHARD HATHAWAY, M.D.

DATE 9/14/89 TIME _____

dict:08/14/89
tran:08/28/89/at;pmp/wdl.28