

AFFIX PATIENT DETAIL STICKER
HERE

NHS Organisation.....

Forename.....

Responsible surgeon.....

Surname.....

Job Title.....

Hospital Number.....

D.O.B...../...../.....

No special requirements o

**OPERATION: Patella Tension Band Wiring
(TBW) – *fixing the kneecap***

PROCEDURE: The knee cap is an important part of the structure of your knee. It is essential in allowing the bend of the knee because your thigh muscles attach onto it. Your patella (knee cap) is broken & your surgeons have recommended that you have it fixed.

Your surgeon will see you before the operation. They will take this opportunity to mark your leg with a felt pen. This is to make sure the correct leg operated upon. If you have any questions, now might be a good time to ask them.

An anaesthetic will be administered in theatre. This may be a general anaesthetic (where you will be asleep) and/ or a regional block (i.e. where you are awake but the area to be operated is completely numbed). You must discuss this and the risks with the anaesthetist.

A tight inflatable band (tourniquet) may be wrapped around your upper thigh to limit the amount of bleeding. The skin is cleaned with antiseptic fluid and surgical drapes (towels) are put around the knee. A cut (incision) is made usually down the middle of the knee. This allows access to the broken bone. When the bone has been held back to a position (as close to normal as possible), the surgeon will try and hold them with 2 thin wires and a looped wire around the knee cap. X-rays can be taken throughout the operation.

When the surgeon is happy with the fixation, the skin can be closed. This is usually done with surgical stitches (sutures) or surgical clips. The sutures or clips will need to be removed in 10 to 14 days.

The arm is often placed in a cast or brace at the end of the operation. You should return to hospital in a fortnight after the operation to allow the team to check the wound.

The metalwork can be left in the kneecap. If it starts to become a problem (is painful, sticks out of the skin or becomes infected), the metal wires will be removed.

You may be encouraged to start to move the knee from an early stage (sometimes a couple of weeks).

*****Please be aware that a surgeon other than the consultant with adequate training or supervision may perform the operation for you*****

ALTERNATIVE PROCEDURE: all broken bones can be left without an operation and treated by resting in a cast. However, they may not set in the right position or may not join at all. Your surgeon believes that your fracture is severe enough to need an operation.

There are several ways to fix this type of fracture. This form suggests how it may be done, but you should discuss the procedure with your consultant.

RISKS

As with all procedures, this carries some risks and complications.

COMMON (2-5%)

Pain: the procedure will hurt afterwards. It is important to discuss with the staff and ask for pain killers if needed. Keeping the leg up (elevated) on a frame or even a footstool will reduce the pain and swelling.

Scar: the operation will leave a thin scar down the middle of the knee. You can discuss the length of this with the surgeon.

Backing out of wires: the wires used to hold the broken bones in position have a habit of “backing out”. If they start to irritate the skin or cause infection, they can be easily removed. The wires can also become prominent.

Stiffness: the knee may not move as freely as it did before. You may require physiotherapy to regain that movement.

RARE (<1%)

Infection: This may present as redness, discharge or temperature around the wound. A course of antibiotics may be necessary once the source has been isolated.

thick/ keloid scar: These are scars which grow excessively (within the wound margin and beyond respectively). Scars may be treated with steroid injection or surgically if necessary.

Delayed wound healing: may occur if the wound is under tension, infected or short of blood supply.

Fat necrosis: this is also a cause of delayed wound healing

Bleeding: there will inevitably be some bleeding, but this is usually controlled at the time of the operation

Neurovascular damage: there are no major nerves and blood vessels that run past the kneecap. However, the cut may lead to numbness at the front of the knee. Also an important nerve called the peroneal nerve which wraps



around one of the shin bones can also be damaged, leading to weakness/ numbness of the foot. This is extremely rare.

Delayed/ non-union: This may happen because the bone is damaged, the bone is poor quality or the bone not adequately fixed. Sometimes we are not sure why the bone doesn't heal. It may require another operation in the future.

DVT/ Blood clot: A DVT (deep vein thrombosis) is a blood clot that forms in the blood vessels. It can be very sore and if the clot travels to the lungs, it can seriously affect your breathing.

Confirmation of consent :

I have read/ understand the procedure, risks and complications. I have asked any questions and raised any immediate concerns I might have. I understand another surgeon other than my consultant may perform the operation.(although they will have adequate training/ supervision).

I understand that I will have the opportunity to discuss the details of anaesthesia with an anaesthetist before the procedure

I understand that any procedure in addition to those described on this form will only be carried out if it is necessary to save my life or to prevent serious harm to my health.

Signature.....

Print name.....

Date...../.../20...

2nd Confirmation..... .Date...../.....20.....

I also give consent for my notes and data to be used in any studies and trials in the future

Signature.....Date.....

NAME of SURGEON (Capital letters).....
SIGNATURE of SURGEON.....
POSITION.....