PREOPERATIVE DIAGNOSIS: , Left carpal tunnel syndrome.,POSTOPERATIVE DIAGNOSIS:, Left carpal tunnel syndrome.,OPERATIVE PROCEDURE PERFORMED:, Left carpal tunnel release.,FINDINGS:, Showed severe compression of the median nerve on the left at the wrist.,SPECIMENS: ,None.,FLUIDS:, 500 mL of crystalloids.,URINE OUTPUT:, No Foley catheter.,COMPLICATIONS: , None.,ANESTHESIA: , General through a laryngeal mask.,ESTIMATED BLOOD LOSS: , None.,CONDITION: , Resuscitated with stable vital signs.,INDICATION FOR THE OPERATION: , This is a case of a very pleasant 65-year-old forensic pathologist who I previously had performed initially a discectomy and removal of infection at 6-7, followed by anterior cervical discectomy with anterior interbody fusion at C5-6 and C6-7 with spinal instrumentation. At the time of initial consultation, the patient was also found to have bilateral carpal tunnel and for which we are addressing the left side now. Operation, expected outcome, risks, and benefits were discussed with him for most of the risk would be that of infection because of the patient's diabetes and a previous history of infection in the form of pneumonia. There is also the possibility of bleeding as well as the possibility of injury to the median nerve on dissection. He understood this risk and agreed to have the procedure performed.,DESCRIPTION OF THE PROCEDURE: , The patient was brought to the operating room, awake, alert, not in any form of distress. After smooth induction of anesthesia and placement of a laryngeal mask, he remained supine on the

operating table. The left upper extremity was then prepped with Betadine soap and antiseptic solution. After sterile drapes were laid out, an incision was made following inflation of blood pressure cuff to 250 mmHg. Clamp time approximately 30 minutes. An incision was then made right in the mid palm area between the thenar and hypothenar eminence. Meticulous hemostasis of any bleeders were done. The fat was identified. The palmar aponeurosis was identified and cut and this was traced down to the wrist. There was severe compression of the median nerve. Additional removal of the aponeurosis was performed to allow for further decompression. After this was all completed, the area was irrigated with saline and bacitracin solution and closed as a single layer using Prolene 4-0 as interrupted vertical mattress stitches. Dressing was applied. The patient was brought to the recovery.