PREOPERATIVE DIAGNOSIS:, Empyema.,POSTOPERATIVE DIAGNOSIS: , Empyema.,PROCEDURE PERFORMED:,1. Right thoracotomy, total decortication.,2. Intraoperative bronchoscopy.,ANESTHESIA: , General.,COMPLICATIONS: , None.,ESTIMATED BLOOD LOSS:, 300 cc.,FLUIDS: , 2600 cc IV crystalloid.,URINE: , 300 cc intraoperatively.,INDICATIONS FOR PROCEDURE: ,The patient is a 46-year-old Caucasian male who was admitted to ABCD Hospital since 08/14/03 with acute diagnosis of right pleural effusion. A thoracostomy tube was placed at the bedside with only partial resolution of the pleural effusion. On CT scan evaluation, there is evidence of an entrapped right lower lobe with loculations. Decision was made to proceed with surgical intervention for a complete decortication and the patient understands the need for surgery and signed the preoperative informed consent.,OPERATIVE PROCEDURE: , The patient was taken to the operative suite and placed in the supine position under general anesthesia per Anesthesia Department. Intraoperative bronchoscopy was performed by Dr. Y and evaluation of carina, left upper and lower lobes with segmental evidence of diffuse mucous, thick secretions which were thoroughly lavaged with sterile saline lavage. Samples were obtained from both the left and the right subbronchiole segments for Gram stain cultures and ASP evaluation. The right bronchus lower, middle, and upper were also examined and subsegmental bronchiole areas were thoroughly examined with no evidence of masses, lesions, or suspicious

extrinsic compressions on the bronchi. At this point, all mucous secretions were thoroughly irrigated and aspirated until the airways were clear. Bronchoscope was then removed. Vital signs remained stable throughout this portion of the procedure. The patient was re-intubated by Anesthesia with a double lumen endotracheal tube. At this point, the patient was repositioned in the left lateral decubitus position with protection of all pressure points and the table was extended in customary fashion. At this point, the right chest was prepped and draped in the usual sterile fashion. The chest tube was removed before prepping the patient and the prior thoracostomy site was cleansed thoroughly with Betadine. The first port was placed through this incision intrathoracically. A bronchoscope was placed for inspection of the intrathoracic cavity. Pictures were taken. There is extensive fibrinous exudate noted under parietal and visceral pleura, encompassing the lung surface, diaphragm, and the posterolateral aspect of the right thorax. At this point, a second port site anteriorly was placed under direct visualization. With the aid of the thoracoscopic view, a Yankauer resection device was placed in the thorax and blunt decortication was performed and aspiration of reminder of the pleural fluid. Due to the gelatinous nature of the fibrinous exudate, there were areas of right upper lobe that adhered to the chest wall and the middle and lower lobes appeared entrapped. Due to the extensive nature of the disease, decision was made to open the chest in a formal right thoracotomy fashion. Incision was made. The subcutaneous

tissues were then electrocauterized down to the level of the latissimus dorsi, which was separated with electrocautery down to the anterior 6th rib space. The chest cavity was entered with the right lung deflated per Anesthesia at our request. Once the intrathoracic cavity was accessed, a thorough decortication was performed in meticulous systematic fashion starting with the right upper lobe, middle, and the right lower lobe. With the expansion of the lung and reduction of the pleural surface fibrinous extubate, warm irrigation was used and the lungs allowed to re-expand. There was no evidence of gross leakage or bleeding at the conclusion of surgery.,Full lung re-expansion was noted upon re-inflation of the lung. Two #32 French thoracostomy tubes were placed, one anteriorly straight and one posteriorly on the diaphragmatic sulcus. The chest tubes were secured in place with #0-silk sutures and placed on Pneumovac suction. Next, the ribs were reapproximated with five interrupted CTX sutures and latissimus dorsi was then reapproximated with a running #2-0 Vicryl suture. Next, subcutaneous skin was closed sequentially with a cosmetic layered subcutaneous closure. Steri-Strips were applied along with sterile occlusive dressings. The patient was awakened from anesthesia without difficulty and extubated in the operating room. The chest tubes were maintained on Pleur-Evac suction for full re-expansion of the lung. The patient was transported to the recovery with vital signs stable. Stat portable chest x-ray is pending. The patient will be admitted to the Intensive Care Unit for close monitoring overnight.