PREOPERATIVE DIAGNOSIS: ,Metastatic renal cell carcinoma.,POSTOPERATIVE DIAGNOSIS:, Metastatic renal cell carcinoma.,PROCEDURE PERFORMED:, Left metastasectomy of metastatic renal cell carcinoma with additional mediastinal lymph node dissection and additional fiberoptic bronchoscopy used to confirm adequate placement of the double-lumen endotracheal tube with a tube thoracostomy, which was used to drain the left chest after the procedure.,ANESTHESIA:, General endotracheal anesthesia with double-lumen endotracheal tube.,FINDINGS:, Multiple pleural surface seeding, many sub-millimeter suspicious looking lesions.,DISPOSITION OF SPECIMENS:,To Pathology for permanent analysis as well as tissue banking. The lesions sent for pathologic analysis were the following,,1. Level 8 lymph node.,2. Level 9 lymph node.,3. Wedge, left upper lobe apex, which was also sent to the tissue bank and possible multiple lesions within this wedge.,4. Wedge, left upper lobe posterior.,5. Wedge, left upper lobe anterior.,6. Wedge, left lower lobe superior segment.,7. Wedge, left lower lobe diaphragmatic surface, anterolateral.,8. Wedge, left lower lobe, anterolateral.,9. Wedge, left lower lobe lateral adjacent to fissure.,10. Wedge, left upper lobe, apex anterior.,11. Lymph node package, additional level 8 lymph node.,ESTIMATED BLOOD LOSS:, Less than 100 mL.,CONDITION OF THE PATIENT AFTER SURGERY: , Stable.,HISTORY OF PROCEDURE: , The patient was given preoperative informed consent for the procedure as well as for the clinical trial he was enrolled into. The patient agreed

based on the risks and the benefits of the procedure, which were presented to him and was taken to the operating room. A correct time out procedure was performed. The patient was placed into the supine position. He was given general anesthesia, was endotracheally intubated without incident with a double-lumen endotracheal tube. Fiberoptic bronchoscopy was used to perform confirmation of adequate placement of the double-lumen tube. Following this, the decision was made to proceed with the surgery. The patient was rolled into the right lateral decubitus position with the left side up. All pressure points were padded. The patient had a sterile DuraPrep preparation to the left chest. A sterile drape around that was applied. Also, the patient had Marcaine infused into the incision area. Following this, the patient had a posterolateral thoracotomy incision, which was a muscle-sparing incision with a posterior approach just over the ausculatory triangle. The incision was approximately 10 cm in size. This was created with a 10-blade scalpel. Bovie electrocautery was used to dissect the subcutaneous tissues. The auscultatory triangle was opened. The posterior aspect of the latissimus muscle was divided from the adjacent tissue and retracted anteriorly. The muscle was not divided. After the latissimus muscle was retracted anteriorly, the ribs were counted, and the sixth rib was identified. The superior surface of the sixth rib was incised with Bovie electrocautery and the sixth rib was divided with rib shears. Following this, the patient had the entire intercostal muscle separated from the superior aspect of the sixth rib on the left as far as the Bovie would

reach. The left lung was allowed to collapse and meticulous inspection of the left lung identified the lesions, which were taken out with stapled wedge resections via a TA30 green load stapler for all of the wedges. The patient tolerated the procedure well without any complications. The largest lesion was the left upper lobe apex lesion, which was possibly multiple lesions, which was taken in one large wedge segment, and this was also adjacent to another area of the wedges. The patient had multiple pleural abnormalities, which were identified on the surface of the lung. These were small white spotty looking lesions and were not confirmed to be tumor implants, but were suspicious to be multiple areas of tumor. Based on this, the wedges of the tumors that were easily palpable were excised with complete excision of all palpable lesions. Following this, the patient had a 32-French chest tube placed in the anteroapical position. A 19-French Blake was placed in the posterior apical position. The patient had the intercostal space reapproximated with #2-0 Vicryl suture, and the lung was allowed to be re-expanded under direct visualization. Following this, the chest tubes were placed to Pleur-evac suction and the auscultatory triangle was closed with 2-0 Vicryl sutures. The deeper tissue was closed with 3-0 Vicryl suture, and the skin was closed with running 4-0 Monocryl suture in a subcuticular fashion. The patient tolerated the procedure well and had no complications.