PREOPERATIVE DIAGNOSIS: ,Thyroid goiter with substernal extension on the left.,POSTOPERATIVE DIAGNOSIS:, Thyroid goiter with substernal extension on the left.,PROCEDURE PERFORMED:, Total thyroidectomy with removal of substernal extension on the left.,THIRD ANESTHESIA: , General endotracheal.,ESTIMATED BLOOD LOSS: , Approximately 200 cc.,COMPLICATIONS: , None.,INDICATIONS FOR PROCEDURE:, The patient is a 54-year-old Caucasian male with a history of an enlarged thyroid gland who presented to the office initially with complaints of dysphagia and some difficulty in breathing while lying supine. The patient subsequently then had a CT scan which demonstrated a very large thyroid gland, especially on the left side with substernal extension down to the level of the aortic arch. The patient was then immediately set up for surgery. After risks, complications, consequences, and questions were addressed with the patient, a written consent was obtained.,PROCEDURE:, The patient was brought to the operative suite by Anesthesia and placed on the operative table in the supine position. The patient was then placed under general endotracheal intubation anesthesia and the patient then had a shoulder roll placed. After this, the patient then had the area marked initially. The preoperative setting was then localized with 1% lidocaine and epinephrine 1:100,000 approximately 10 cc total. After this, the patient was then prepped and draped in the usual sterile fashion. A #15 Bard-Parker was then utilized to make a skin incision horizontally, approximately 5 cm on either side from midline.

After this, a blunt dissection was then utilized to dissect the subcutaneous fat from the platysmal muscle. There appeared to be a natural dehiscence of the platysma in the midline. A sub-platysmal dissection was then performed in the superior, inferior, and lateral directions with the help of a bear claw, Metzenbaum scissors and DeBakey forceps. Any bleeding was controlled with monopolar cauterization. After this, the two anterior large jugular veins were noted and resected laterally. The patient's trachea appeared to be slightly deviated to the right with identification finally of the midline raphe, off midline to the right. This was grasped on either side with a DeBakey forceps and dissected with monopolar cauterization and dissected with a Metzenbaum scissors. After this was dissected, the sternohyoid muscles were resected laterally and separated from the sternothyroid muscles. The sternothyroid muscles were then bluntly freed and dissected from the right thyroid gland. After this, attention was then drawn to the left gland, where the sternothyroid muscle was dissected bluntly on this side utilizing finger dissection and Kitners. The left thyroid gland was freed initially superiorly and worked inferiorly and laterally until the gland was pulled from the substernal region by blunt dissection and reflected and pulled anteriorly. After this, the superior and inferior parathyroid glands were noted. The dissection was carried very close to the thyroid gland to try to select these parathyroids posteriorly. After this, the superior pole was then identified and the superior laryngeal artery and vein were cross clamped and tied with _____ undyed

Vicryl tie. The superior pole was finally freed and a small little feeding branched vessels from this area were cauterized with the bipolar cautery and cut with Metzenbaum scissors. After this, the thyroid gland was further freed down to the level of the Berry's ligament inferiorly and the dissection was carried once again more superiorly. The fine stats were then utilized to dissect along the superior aspect of the recurrent laryngeal nerve on the left side with freeing of the connective Berry's ligament tissue from the gland with the bipolar cauterization and the fine stat. Finally, attention was then drawn back to the patient's right side where the gland was rotated more anteriorly with fine dissection utilizing a fine stat to reflect the superior and inferior parathyroid glands laterally and posteriorly. The recurrent laryngeal nerve on this side was identified and further dissection was carried superiorly and anteriorly through this nerve to finally free the right side of the gland to Berry's ligament. The middle thyroid vein and inferior thyroid arteries were cross clamped and tied with #2-0 undyed Vicryl ties and also bipolared with the bipolar cauterization bilaterally. The Berry's ligament was then finally freed and the gland was then passed to scrub tech and passed off the field to Pathology. The neck was then thoroughly irrigated with normal saline solution and further bleeding was controlled with bipolar cauterization. After this, Surgicel was then placed in the bilateral neck regions and a #10 Jackson-Pratt drain was then placed within the left neck region with some extension over to the right neck region. This was brought out through the inferior skin incision and secured to the skin with a

#2-0 nylon suture. The strap muscles were then reapproximated with a running #3-0 Vicryl suture followed by reapproximation of the platysma and subcutaneous tissue with a #4-0 undyed Vicryl. The skin was then reapproximated with a #5-0 Prolene subcuticular along with a #6-0 fast over the top. After this, Mastisol Steri-Strips and Bacitracin along with a sterile dressing and a _____ dressing were then placed. The patient intraoperatively did have approximately 50 cc of bloody drainage from this area within the JP drain. The patient was then turned back to Anesthesia, extubated in the operating room and transferred to Recovery in stable condition. The patient tolerated the procedure well and remained stable throughout.