

TITLE OF OPERATION: ,Total thyroidectomy for goiter.,INDICATION FOR SURGERY: ,This is a 41-year-old woman who notes that compressive thyroid goiter and symptoms related to such who wishes to undergo surgery. Risks, benefits, alternatives of the procedures were discussed in great detail with the patient. Risks include but were not limited to anesthesia, bleeding, infection, injury to nerve, vocal fold paralysis, hoarseness, low calcium, need for calcium supplementation, tumor recurrence, need for additional treatment, need for thyroid medication, cosmetic deformity, and other. The patient understood all these issues and they wished to proceed.,PREOP DIAGNOSIS: , Multinodular thyroid goiter with compressive symptoms and bilateral dominant thyroid nodules proven to be benign by fine needle aspiration.,POSTOP DIAGNOSIS: , Multinodular thyroid goiter with compressive symptoms and bilateral dominant thyroid nodules proven to be benign by fine needle aspiration.,ANESTHESIA: , General endotracheal.,PROCEDURE DETAIL: , After identifying the patient, the patient was placed supine in a operating room table. After establishing general anesthesia via oral endotracheal intubation with a 6 Nerve Integrity monitoring system endotracheal tube. The eyes were then tacked with Tegaderm. The Nerve Integrity monitoring system, endotracheal tube was confirmed to be working adequately. Essentially a 7 cm incision was employed in the lower skin crease of the neck. A 1% lidocaine with 1:100,000 epinephrine were given. Shoulder roll was applied. The

patient prepped and draped in a sterile fashion. A 15-blade was used to make the incision. Subplatysmal flaps were raised to the thyroid notch and sternal respectively. The strap muscles were separated in the midline. As we then turned to the left side where the sternohyoid muscle was separated from the sternothyroid muscle there was a very dense and firm thyroid mass on the left side. The sternothyroid muscle was transected horizontally. Similar procedure was performed on the right side. Attention was then turned to identify the trachea in the midline. Veins in this area and the pretracheal region were ligated with a harmonic scalpel. Subsequently, attention was turned to dissecting the capsule off of the left thyroid lobe. Again this was very firm in nature. The superior thyroid pole was dissected in the superior third artery, vein, and the individual vessels were ligated with a harmonic scalpel. The inferior and superior parathyroid glands were protected. Recurrent laryngeal nerve was identified in the tracheoesophageal groove. This had arborized early as a course underneath the inferior thyroid artery to a very small tiny anterior motor branch. This was followed superiorly. The level of cricothyroid membrane upon complete visualization of the entire nerve, Berry's ligament was transected and the nerve protected and then the thyroid gland was dissected over the trachea. A prominent pyramidal level was also appreciated and dissected as well. Attention was then turned to the right side. There was significant amount of thyroid tissue that was very firm. Multiple nodules were appreciated. In a similar fashion, the capsule was dissected. The superior

and inferior parathyroid glands protected and preserved. The superior thyroid artery and vein were individually ligated with the harmonic scalpel and the inferior thyroid artery was then ligated close to the thyroid gland capsule. Once the recurrent laryngeal nerve was identified again on this side, the nerve had arborized early prior to the coursing underneath the inferior thyroid artery. The anterior motor branch was then very fine, almost filamentous and stimulated at 0.5 milliamps, completely dissected toward the cricothyroid membrane with complete visualization. A small amount of tissue was left at the Berry's ligament as the remainder of thyroid level was dissected over the trachea. The entire thyroid specimen was then removed, marked with a stitch upon the superior pole. The wound was copiously irrigated, Valsalva maneuver was given, bleeding points controlled. The parathyroid glands appeared to be viable. Both the anterior motor branches that were tiny were stimulated at 5 milliamps and confirmed to be working with the Nerve Integrity monitoring system., Attention was then turned to burying the Surgicel on the wound bed on both sides. The strap muscles were reapproximated in the midline using a 3-0 Vicryl suture of the sternothyroid horizontal transection and the strap muscles in the midline were then reapproximated. The 1/8th inch Hemovac drain was placed and secured with a 3-0 nylon. The incision was then closed with interrupted 3-0 Vicryl and Indermil for the skin. The patient has a history of keloid formation and approximately 1 cubic centimeter of 40 mg per cubic centimeter Kenalog was injected into the incisional line using

a tuberculin syringe and 25-gauge needle. The patient tolerated the procedure well, was extubated in the operating room table, and sent to postanesthesia care unit in a good condition. Upon completion of the case, fiberoptic laryngoscopy revealed intact bilateral true vocal fold mobility.