PREOPERATIVE DIAGNOSIS: , Thyroid goiter.,POSTOPERATIVE DIAGNOSIS: ,Thyroid goiter.,PROCEDURE PERFORMED: , Total thyroidectomy.,ANESTHESIA:,1. General endotracheal anesthesia.,2. 9 cc of 1% lidocaine with 1:100,000 epinephrine.,COMPLICATIONS:, None.,PATHOLOGY: , Thyroid.,INDICATIONS: ,The patient is a female with a history of Graves disease. Suppression was attempted, however, unsuccessful. She presents today with her thyroid goiter. A thyroidectomy was indicated at this time secondary to the patient's chronic condition. Indications, alternatives, risks, consequences, benefits, and details of the procedure including specifically the risk of recurrent laryngeal nerve paresis or paralysis or vocal cord dysfunction and possible trach were discussed with the patient in detail. She agreed to proceed. A full informed consent was obtained.,PROCEDURE: , The patient presented to ABCD General Hospital on 09/04/2003 with the history was reviewed and physical examinations was evaluated. The patient was brought by the Department of Anesthesiology, brought back to surgical suite and given IV access and general endotracheal anesthesia. A 9 cc of 1% lidocaine with 1:100,000 of epinephrine was infiltrated into the area of pre-demarcated above the suprasternal notch. Time is allowed for full hemostasis to be achieved. The patient was then prepped and draped in the normal sterile fashion. A #10 blade was then utilized to make an incision in the pre-demarcated and anesthetized area. Unipolar electrocautery was utilized for

hemostasis. Finger dissection was carried out in the superior and inferior planes. Platysma was identified and dissected and a subplatysmal plane was created in the superior and inferior, medial and lateral directions using hemostat, Metzenbaum, and blunt dissection. The strap muscles were identified. The midline raphe was not easily identifiable at this time. An incision was made through what appeared to be in the midline raphe and dissection was carried down to the thyroid. Sternohyoid and sternothyroid muscles were identified and separated on the patient's right side and then subsequently on the left side. It was noted at this time that the thyroid lobule on the right side is a bi-lobule. Kitner blunt dissection was utilized to bluntly dissect the overlying thyroid fascia as well as strap muscles off the thyroid, force in the lateral direction. This was carried down to the inferior and superior areas. The superior pole of the right lobule was then identified. A hemostat was placed in the cricothyroid groove and a Kitner was placed in this area. A second Kitner was placed on lateral aspect of the superior pole and the superior pole of the right thyroid was retracted inferiorly. Careful dissection was then carried out in a very meticulous fashion in the superior lobe and identified the appropriate vessels and cauterized with bipolar or ligated with the suture ligature. This was carried out until the superior pole was identified. Careful attention was made to avoid nerve injury in this area. Dissection was then carried down again bluntly separating the inferior and superior lobes. The bilobed right thyroid was then retracted medially. The recurrent laryngeal nerve was then

identified and tracked to its insertion. The overlying vessels of the middle thyroid vein as well as the associated structures were then identified and great attention was made to perform a right careful meticulous dissection to remove the fascial attachments superficial to the recurrent laryngeal nerve off the thyroid. When it was completed, this lobule was then removed from Berry's ligament. There was noted to be no isthmus at this time and the entire right lobule was then sent to the Pathology for further evaluation. Attention was then diverted to the patient's left side. In a similar fashion, the sternohyoid and sternothyroid muscles were already separated. Army-Navy as well as femoral retractors were utilized to lateralize the appropriate musculature. The middle thyroid vein was identified. Blunt dissection was carried out laterally to superiorly once again. A hemostat was utilized to make an opening in the cricothyroid groove and a Kitner was then placed in this area. Another Kitner was placed on the lateral aspect of the superior lobe of the left thyroid and retracted inferiorly. Once again, a careful meticulous dissection was utilized to identify the appropriate structures in the superior pole of the left thyroid and suture ligature as well as bipolar cautery was utilized for hemostasis. Once again, a careful attention was made not to injure the nerve in this area. The superior pole was then freed appropriately and blunt dissection was carried down to lateral and inferior aspects. The inferior aspect was then identified. The inferior thyroid artery and vein were then identified and ligated. The left thyroid was then medialized and the recurrent laryngeal nerve

has been identified. A careful dissection was then carried out to remove the fascial attachments superficial to the recurrent laryngeal nerve on the side as close to the thyroid gland as possible. The thyroid was then removed from the Berry's ligament and it was then sent to Pathology for further evaluation. Evaluation of the visceral space did not reveal any bleeding at this time. This was irrigated and pinpoint areas were bipolored as necessary. Surgicel was then placed bilaterally. The strap muscles as well as the appropriate fascial attachments were then approximated with a #3-0 Vicryl suture in the midline. The platysma was identified and approximated with a #4-0 Vicryl suture and the subdermal plane was approximated with a #4-0 Vicryl suture. A running suture consisting of #5-0 Prolene suture was then placed and fast absorbing #6-0 was then placed in a running fashion. Steri-Strips, Tincoban, bacitracin and a pressure gauze was then placed. The patient was then admitted for further evaluation and supportive care. The patient tolerated the procedure well. The patient was transferred to Postanesthesia Care Unit in stable condition.