

PREOPERATIVE/POSTOPERATIVE DIAGNOSES:,1.

Severe tracheobronchitis.,2. Mild venous engorgement with question varicosities associated pulmonary hypertension.,3.

Right upper lobe submucosal hemorrhage without frank mass underneath it status post biopsy.,PROCEDURE

PERFORMED: , Flexible fiberoptic bronchoscopy with:,a.

Right lower lobe bronchoalveolar lavage.,b. Right upper lobe endobronchial biopsy.,SAMPLES: , Bronchoalveolar lavage

for cytology and for microbiology of the right lower lobe

endobronchial biopsy of the right upper lobe.,INDICATIONS: ,

The patient with persistent hemoptysis of unclear

etiology.,PROCEDURE: , After obtaining informed consent,

the patient was brought to Bronchoscopy Suite. The patient

had previously been on Coumadin and then heparin. Heparin

was discontinued approximately one-and-a-half hours prior to

the procedure. The patient underwent topical anesthesia with

10 cc of 4% Xylocaine spray to the left nares and

nasopharynx. Blood pressure, EKG, and oximetry monitoring

were applied and monitored continuously throughout the

procedure. Oxygen at two liters via nasal cannula was

delivered with saturations in the 90% to 100% throughout the

procedure. The patient was premedicated with 50 mg of

Demerol and 2 mg of Versed. After conscious sedation was

achieved, the bronchoscope was advanced through the left

nares into the nasopharynx and oropharynx. There was

minimal redundant oral soft tissue in the oropharynx. There

was mild erythema. Clear secretions were

suctioned.,Additional topical anesthesia was applied to the

larynx and then throughout the tracheobronchial tree for the procedure, a total of 16 cc of 2% Xylocaine was applied. Vocal cord motion was normal. The bronchoscope was then advanced through the larynx into the trachea. There was evidence of moderate inflammation with prominent vascular markings and edema. No frank blood was visualized. The area was suction clear of copious amounts of clear white secretions. Additional topical anesthesia was applied and the bronchoscope was advanced into the left main stem. The bronchoscope was then sequentially advanced into each segment and sub-segment of the left upper lobe and left lower lobe. There was significant amount of inflammation, induration, and vascular tortuosity in these regions. No frank blood was identified. No masses or lesions were identified. There was senile bronchiectasis with slight narrowing and collapse during the exhalation. The air was suctioned clear. The bronchoscope was withdrawn and advanced into the right main stem. Bronchoscope was introduced into the right upper lobe and each sub-segment was visualized. Again significant amounts of tracheobronchitis was noted with vascular infiltration. In the sub-carina of the anterior segment of the right upper lobe, there was evidence of a submucosal hematoma without frank mass underneath this. The bronchoscope was removed and advanced into the right middle and right lower lobe. There was marked injection and inflammation in these regions. In addition, there was marked vascular engorgement with near frank varicosities identified throughout the region. Again, white clear secretions were

identified. No masses or other processes were noted. The area was suctioned clear. A bronchoalveolar lavage was subsequently performed in the anterior segment of the right lower lobe. The bronchoscope was then withdrawn and readvanced into the right upper lobe. Endobronchial biopsies of the carina of the sub-segment and anterior segment of the right upper lobe were obtained. Minimal hemorrhage occurred after the biopsy, which stopped after 1 cc of 1:1000 epinephrine. The area remained clear. No further hemorrhage was identified. The bronchoscope was subsequently withdrawn. The patient tolerated the procedure well and was stable throughout the procedure. No further hemoptysis was identified. The patient was sent to Recovery in good condition.