

PREOPERATIVE DIAGNOSIS:, Posterior mediastinal mass with possible neural foraminal

involvement.,POSTOPERATIVE DIAGNOSIS: , Posterior mediastinal mass with possible neural foraminal involvement (benign nerve sheath tumor by frozen section).,OPERATION

PERFORMED:, Left thoracotomy with resection of posterior mediastinal mass.,INDICATIONS FOR PROCEDURE: ,The

patient is a 23-year-old woman who recently presented with a posterior mediastinal mass and on CT and MRI there were some evidence of potential widening of one of the neural foramina. For this reason, Dr. X and I agreed to operate on this patient together. Please note that two surgeons were required for this case due to the complexity of it. The

indications and risks of the procedure were explained and the patient gave her informed consent.,DESCRIPTION OF

PROCEDURE: , The patient was brought to the operating suite and placed in the supine position. General endotracheal anesthesia was given with a double lumen tube. The patient was positioned for a left thoracotomy. All pressure points were carefully padded. The patient was prepped and draped in usual sterile fashion. A muscle sparing incision was created several centimeters anterior to the tip of the scapula. The serratus and latissimus muscles were retracted. The intercostal space was opened. We then created a thoracoscopy port inferiorly through which we placed a camera for lighting and for visualization. Through our small anterior thoracotomy and with the video-assisted scope placed inferiorly we had good visualization of the posterior

mediastinum mass. This was in the upper portion of the mediastinum just posterior to the subclavian artery and aorta. The lung was deflated and allowed to retract anteriorly. With a combination of blunt and sharp dissection and with attention paid to hemostasis, we were able to completely resect the posterior mediastinal mass. We began by opening the tumor and taking a very wide large biopsy. This was sent for frozen section, which revealed a benign nerve sheath tumor. Then, using the occluder device Dr. X was able to \_\_\_\_\_ the inferior portions of the mass. This left the external surface of the mass much more malleable and easier to retract. Using a bipolar cautery and endoscopic scissors we were then able to completely resect it. Once the tumor was resected, it was then sent for permanent sections. The entire hemithorax was copiously irrigated and hemostasis was complete. In order to prevent any lymph leak, we used 2 cc of Evicel and sprayed this directly on to the raw surface of the pleural space. A single chest tube was inserted through our thoracoscopy port and tunneled up one interspace. The wounds were then closed in multiple layers. A #2 Vicryl was used to approximate the ribs. The muscles of the chest wall were allowed to return to their normal anatomic position. A 19 Blake was placed in the subcutaneous tissues. Subcutaneous tissues and skin were closed with running absorbable sutures. The patient was then rolled in the supine position where she was awakened from general endotracheal anesthesia and taken to the recovery room in stable condition.