PREOPERATIVE DIAGNOSIS: , Right carpal tunnel syndrome.,POSTOPERATIVE DIAGNOSIS:, Right carpal tunnel syndrome.,PROCEDURE PERFORMED: , Right carpal tunnel release.,PROCEDURE NOTE: ,The right upper extremity was prepped and draped in the usual fashion. IV sedation was supplied by the anesthesiologist. A local block using 6 cc of 0.5% Marcaine was used at the transverse wrist crease using a 25 gauge needle, superficial to the transverse carpal ligament.,The upper extremity was exsanguinated with a 6 inch ace wrap.,Tourniquet time was less than 10 minutes at 250 mmHg.,An incision was used in line with the third web space just to the ulnar side of the thenar crease. It was carried sharply down to the transverse wrist crease. The transverse carpal ligament was identified and released under direct vision. Proximal to the transverse wrist crease it was released subcutaneously. During the entire procedure care was taken to avoid injury to the median nerve proper, the recurrent median, the palmar cutaneous branch, the ulnar neurovascular bundle and the superficial palmar arch. The nerve appeared to be mildly constricted. Closure was routine with running 5-0 nylon. A bulky hand dressing as well as a volar splint was applied and the patient was sent to the outpatient surgery area in good condition.