OPERATION,1. Right upper lung lobectomy.,2. Mediastinal lymph node dissection.,ANESTHESIA,1. General endotracheal anesthesia with dual-lumen tube.,2. Thoracic epidural.,OPERATIVE PROCEDURE IN DETAIL: , After obtaining informed consent from the patient, including a thorough explanation of the risks and benefits of the aforementioned procedure, the patient was taken to the operating room, and general endotracheal anesthesia was administered with a dual-lumen tube. Next, the patient was placed in the left lateral decubitus position, and his right chest was prepped and draped in the standard surgical fashion. We used a #10-blade scalpel to make an incision in the skin approximately 1 fingerbreadth below the angle of the scapula. Dissection was carried down in a muscle-sparing fashion using Bovie electrocautery. The 5th rib was counted, and the 6th interspace was entered. The lung was deflated. We identified the major fissure. We then began by freeing up the inferior pulmonary ligament, which was done with Bovie electrocautery. Next, we used Bovie electrocautery to dissect the pleura off the lung. The pulmonary artery branches to the right upper lobe of the lung were identified. Of note was the fact that there was a visible, approximately 4 x 4-cm mass in the right upper lobe of the lung without any other metastatic disease palpable. As mentioned, a combination of Bovie electrocautery and sharp dissection was used to identify the pulmonary artery branches to the right upper lobe of the lung. Next, we began by ligating the pulmonary artery branches of the right upper lobe of the lung. This was done with suture

ligature in combination with clips. After taking the pulmonary artery branches of the right upper lobe of the lung, we used a combination of blunt dissection and sharp dissection with Metzenbaum scissors to separate out the pulmonary vein branch of the right upper lobe of the lung. This likewise was ligated with a 0 silk. It was stick-tied with a 2-0 silk. It was then divided. Next we dissected out the bronchial branch to the right upper lobe of the lung. A curved Glover was placed around the bronchus. Next a TA-30 stapler was fired across the bronchus. The bronchus was divided with a #10-blade scalpel. The specimen was handed off. We next performed a mediastinal lymph node dissection. Clips were applied to the base of the feeding vessels to the lymph nodes. We inspected for any signs of bleeding. There was minimal bleeding. We placed a #32-French anterior chest tube, and a #32-French posterior chest tube. The rib space was closed with #2 Vicryl in an interrupted figure-of-eight fashion. A flat Jackson-Pratt drain, #10 in size, was placed in the subcutaneous flap. The muscle layer was closed with a combination of 2-0 Vicryl followed by 2-0 Vicryl, followed by 4-0 Monocryl in a running subcuticular fashion. Sterile dressing was applied. The instrument and sponge count was correct at the end of the case. The patient tolerated the procedure well and was transferred to the PACU in good condition.