PREOPERATIVE DIAGNOSIS: , Right carpal tunnel syndrome.,POSTOPERATIVE DIAGNOSIS: , Right carpal tunnel syndrome.,TITLE OF THE PROCEDURE: , Right carpal tunnel release.,COMPLICATIONS:, There were no complications during the procedure.,SPECIMEN: ,The specimen was sent to pathology.,INSTRUMENTS: , All counts were correct at the end of the case and no complications were encountered.,INDICATIONS: ,This is a 69-year-old female who have been complaining of right hand pain, which was steadily getting worse over a prolonged period of time. The patient had tried nonoperative therapy, which did not assist the patient. The patient had previous diagnosis of carpal tunnel and EMG showed compression of the right median nerve. As a result of these findings, the patient was sent to my office presenting with this history and was carefully evaluated. On initial evaluation, the patient had the symptomology of carpal tunnel syndrome. The patient at the time had the risks, benefits, and alternatives thoroughly explained to her. All questions were answered. No guarantees were given. The patient had agreed to the surgical procedure and the postoperative rehabilitation as needed.,DETAILS OF THE PROCEDURE: ,The patient was brought to the operating room, placed supine on the operating room table, prepped and draped in the sterile fashion and was given sedation. The patient was then given sedation. Once this was complete, the area overlying the carpal ligament was carefully injected with 1% lidocaine with epinephrine. The patient had this area carefully and thoroughly injected with approximately 10 mL of

lidocaine with epinephrine and once this was complete, a 15-blade knife was then used to incise the skin opposite the radial aspect of the fourth ray. Careful dissection under direct visualization was performed through the subcutaneous fat as well as through the palmar fascia. A Weitlaner retractor was then used to retract the skin and careful dissection through the palmar fascia would then revealed the transverse carpal ligament. This was then carefully incised using a 15-blade knife and once entry was again into the carpal canal, a Freer elevator was then inserted and under direct visualization, the carpal ligament was then released. The transverse carpal ligament was carefully released first in the distal direction until palmar fat could be visualized and by palpation no further ligament could be felt. The area was well hemostased with the 1% lidocaine with epinephrine and both proximal and distal dissection along the nerve was performed. Visualization of the transverse carpal ligament was maintained with Weitlaner retractor as well as centric. Both the centric and the Ragnell were used to retract both proximal and distal corners of the incision and the entirety of the area was under direct visualization at all times. Palmar fascia was released both proximally and distally as well as the transverse carpal ligament. Direct palpation of the carpal canal demonstrated a full and complete release. Observation of the median nerve revealed an area of hyperemia in the distal two-thirds of the nerve, which demonstrated the likely area of compression. Once this was complete, hemostasis was established using bipolar cautery and some small surface bleeders and

irrigation of the area was performed and then the closure was achieved with 4-0 chromic suture in a horizontal mattress and interrupted stitch. Xeroform was then applied to the incision. A bulky dressing was then applied consisting of Kerlix and Ace wrap, and the patient was taken to the recovery room in stable condition without any complications.