TITLE OF OPERATION:, Completion thyroidectomy with limited right paratracheal node dissection.,INDICATION FOR SURGERY:, A 49-year-old woman with a history of a left dominant nodule in her thyroid gland, who subsequently underwent left thyroid lobectomy and isthmusectomy, was found to have multifocal papillary thyroid carcinoma throughout her left thyroid lobe and isthmus. Consideration given to completion thyroidectomy. Risks, benefits, and alternatives of this procedure was discussed with the patient in great detail. Risks included but were not limited to anesthesia, bleeding, infection, injury to nerves including vocal fold paralysis, hoarseness, low calcium, scar, cosmetic deformity, need for thyroid hormone replacement, and also need for further management. The patient understood all of this and then wished to proceed.,PREOP DIAGNOSIS:, Multifocal thyroid carcinoma and previous left thyroid lobectomy resection specimen.,POSTOP DIAGNOSIS: , Multifocal thyroid carcinoma and previous left thyroid lobectomy resection specimen.,PROCEDURE DETAIL:, After identifying the patient, the patient was placed supine in the operating room table. After establishment of general anesthesia via orotracheal intubation with a number 6 nerve integrity monitoring system endotracheal tube, the eyes were protected with Tegaderm. Nerve integrity monitoring system endotracheal tube was confirmed to be working adequately and secured. The previous skin incision for a thyroidectomy was then planned, then incorporated into an ellipse. The patient was prepped and draped in a sterile fashion.

Subsequently, the ellipse around the previous incision was deformed. The scar was then excised. Subplatysmal flaps were raised to the thyroid notch and sternal notch respectively. Strap muscles were isolated in the midline and dissected and mobilized from the thyroid lobe on the right side. There was some dense fibrosis and inflammation surrounding the right thyroid lobe. Careful dissection along the thyroid lobe allowed for identification of the superior thyroid artery and vein which were individually ligated with a Harmonic scalpel. The right inferior and superior parathyroid glands were identified and preserved and recurrent laryngeal nerve was identified and traced superiorly, then preserved. Of note is that there were multiple lymph nodes in the paratracheal region on the right side. These lymph nodes were carefully dissected away from the recurrent laryngeal nerve, trachea, and the carotid artery, and sent as a separate specimen labeled right paratracheal lymph nodes. The wound was copiously irrigated. Valsalva maneuver was given. Surgicel was placed in the wound bed. Strap muscles were reapproximated in the midline with 3-0 Vicryl and incision was then closed with interrupted 3-0 Vicryl and Indermil for the skin. The patient was extubated in the operating room table, sent to the postanesthesia care unit in good condition.