PROCEDURES PERFORMED,1. Insertion of subclavian dual-port Port-A-Cath.,2. Surgeon-interpreted fluoroscopy.,OPERATIVE PROCEDURE IN DETAIL: , After obtaining informed consent from the patient, including a thorough explanation of the risks and benefits of the aforementioned procedure, patient was taken to the operating room and general endotracheal anesthesia was administered. Next, the chest was prepped and draped in a standard surgical fashion. A #18-gauge spinal needle was used to aspirate blood from the subclavian vein. After aspiration of venous blood, Seldinger technique was used to thread a J wire. The distal tip of the J wire was confirmed to be in adequate position with surgeon-interpreted fluoroscopy. Next a #15-blade scalpel was used to make an incision in the skin. Dissection was carried down to the level of the pectoralis muscle. A pocket was created. A dual-port Port-A-Cath was lowered into the pocket and secured with #2-0 Prolene. Both ports were flushed. The distal tip was pulled through to the wire exit site with a Kelly clamp. It was cut to the appropriate length. Next a dilator and sheath were threaded over the J wire. The J wire and dilator were removed, and the distal tip of the dual-port Port-A-Cath was threaded over the sheath, which was simultaneously withdrawn. Both ports of the dual-port Port-A-Cath were flushed and aspirated without difficulty. The distal tip was confirmed to be in adequate position with surgeon-interpreted fluoroscopy. The wire access site was closed with a 4-0 Monocryl. The port pocket was closed in 2 layers with 2-0 Vicryl followed by 4-0

Monocryl in a running subcuticular fashion. Sterile dressing was applied. The patient tolerated the procedure well and was transferred to the PACU in good condition