PREOPERATIVE DIAGNOSIS: , Ovarian cancer.,POSTOPERATIVE DIAGNOSIS:, Ovarian cancer.,OPERATION PERFORMED:, Insertion of a Port-A-Catheter via the left subclavian vein approach under fluoroscopic guidance.,DETAILED OPERATIVE NOTE:, The patient was placed on the operating table and placed under LMA general anesthesia in preparation for insertion of a Port-A-Catheter. The chest was prepped and draped in the routine fashion for insertion of a Port-A-Catheter. The left subclavian vein was punctured with a single stick and a guidewire threaded through the needle into the superior vena cava under fluoroscopic guidance. The needle was removed. An incision was made over the guidewire for entrance of the dilator with sheath. A second counter incision was made transversally on the chest wall about an inch and half below the puncture site with a #15 blade. Hemostasis was effective to electrocautery, and a pocket was fashioned subcutaneously for positioning of the reservoir. The Port-A-Catheter reservoir tubing was attached to the reservoir in the routine fashion. The reservoir was placed in the pocket and sutured to the anterior chest wall muscle with three interrupted 4-0 Prolene sutures for stability. Next, a catheter passer was passed from the pocket exiting through the skin at the puncture site, previously placed for the guidewire, and the Port-A-Catheter was pulled from the reservoir exiting on the skin. It was placed on the chest, measured, and cut to the appropriate length. This having been done, the dilator with sheath attached was passed over the guidewire into the

superior vena cava under fluoroscopic guidance. The guidewire and dilator were removed, and the Port-A-Catheter was threaded through the sheath into the superior vena cava, and the sheath removed under fluoroscopic guidance. Fluoroscopy revealed the Port-A-Catheter to be in excellent position. The Port-A-Catheter was accessed with a butterfly 90-degree needle percutaneously that drew blood well and flushed easily. It was flushed with heparinized saline connected in cath. This having been done, the puncture site was closed with a circumferential subcutaneous 3-0 Vicryl suture, and the skin was closed with a percutaneous circumferential subcuticular suture. This having been done, attention was applied to the reservoir incision. It was closed with two layers of continuous 3-0 Vicryl suture, and the skin was closed with a continuous 3-0 Monocryl subcuticular stitch. A dry sterile dressing was applied, and the patient having tolerated the procedure was transferred to the recovery room for postoperative care.