PREOPERATIVE DIAGNOSES,1. Bilateral bronchopneumonia.,2. Empyema of the chest, left.,POSTOPERATIVE DIAGNOSES,1. Bilateral bronchopneumonia.,2. Empyema of the chest, left.,PROCEDURES,1. Diagnostic bronchoscopy.,2. Limited left thoracotomy with partial pulmonary decortication and insertion of chest tubes x2.,DESCRIPTION OF PROCEDURE:, After obtaining an informed consent, the patient was taken to the operating room where a time-out process was followed. Initially, the patient was intubated with a #6 French tube because of the presence of previous laryngectomy. Because of this, I proceeded to use a pediatric bronchoscope, which provided limited visualization, but I was able to see the trachea and the carina and both left and right bronchial systems without significant pathology, although there was some mucus secretion that was aspirated.,Then, with the patient properly anesthetized and looking very stable, we decided to insert a larger endotracheal tube that allowed for the insertion of the regular adult bronchoscope. Therefore, we were able to obtain a better visualization and see the trachea and the carina that were normal and also the left and right bronchial systems. Some brownish secretions were obtained, particularly from the right side and were sent for culture and sensitivity, both aerobic and anaerobic fungi and acid fast.,Then, the patient was turned with left side up and prepped for a left thoracotomy. He was properly draped. I had recently re-inspected the CT of the chest and decided to make a limited thoracotomy of about 6 cm or so in the midaxillary

line about the sixth intercostal space. Immediately, it was evident that there was a large amount of pus in the left chest. We proceeded to insert the suction catheters and we rapidly obtained about 1400 mL of frank pus. Then, we proceeded to open the intercostal space a bit more with a Richardson retractor and it was immediately obvious that there was an abundant amount of solid exudate throughout the lung. We spent several minutes trying to clean up this area. Initially, I had planned only to drain the empyema because the patient was in a very poor condition, but at this particular moment, he was more stable and well oxygenated, and the situation was such that we were able to perform a partial pulmonary decortication where we broke up a number of loculations that were present and we were able to separate the lung from the diaphragm and also the pulmonary fissure. On the upper part of the chest, we had limited access, but overall we obtained a large amount of solid exudate and we were able to break out loculations. We followed by irrigation with 2000 cc of warm normal saline and then insertion of two #32 chest tubes, which are the largest one available in this institution; one we put over the diaphragm and the other one going up and down towards the apex.,The limited thoracotomy was closed with heavy intercostal sutures of Vicryl, then interrupted sutures of #0 Vicryl to the muscle layers, and I loosely approximately the skin with a few sutures of nylon because I am suspicious that the incision may become infected because he has been exposed to intrapleural pus.,The chest tubes were secured with sutures and then connected to Pleur-evac. Then, the

patient was transported.,Estimated blood loss was minimal and the patient tolerated the procedure well. He was extubated in the operating room and he was transferred to the ICU to be admitted. A chest x-ray was ordered stat.