PREOPERATIVE DIAGNOSES:,1. Non-small-cell carcinoma of the left upper lobe.,2. History of lymphoma in remission.,POSTOPERATIVE DIAGNOSES:,1. Non-small-cell carcinoma of the left upper lobe.,2. History of lymphoma in remission.,PROCEDURE: , Left muscle sparing mini thoracotomy with left upper lobectomy and mediastinal lymph node dissection. Intercostal nerve block for postoperative pain relief at five levels.,INDICATIONS FOR THE PROCEDURE: , This is an 84-year-old lady who was referred by Dr. A for treatment of her left upper lobe carcinoma. The patient has a history of lymphoma and is in remission. An enlarged right axillary lymph node was biopsied recently and was negative for lymphoma. A mass in the left upper lobe was biopsied with fine-needle aspiration and shown to be a primary non-small-cell carcinoma of the lung. PET scan was, otherwise, negative for spread and resection was advised. All the risk and benefits were fully explained to the patient and she elected to proceed as planned. She was transferred to rehab for couple of weeks to buildup strength before the surgery.,PROCEDURE IN DETAIL:, In the operating room under anesthesia, she was prepped and draped suitably. Dr. B was the staff anesthesiologist. Left muscle sparing mini thoracotomy was made. The serratus and latissimus muscles were not cut but moved out to the way. Access to the chest was obtained through the fifth intercostal space. Two Tuffier retractors of right angles provided adequate exposure.,The inferior pulmonary ligament was not dissected free and lymph nodes from the station 9

were now sent for pathology. The parietal pleural reflexion around the hilum was now circumcised, and lymph nodes were taken from station 8 and station 5.,The branches of the pulmonary artery to the upper lobe were now individually stapled with a 30/2.5 staple gun or/and the smaller one were ligated with 2-0 silk. The left superior pulmonary vein was transected using a TA30/2.5 staple gun, and the fissure was completed using firings of an endo-GIA 60/4.8 staple gun. Finally, the left upper lobe bronchus was transected using a TA30/4.8 staple gun. Please note, that this patient had been somewhat unusual variant of a small bronchus that was coming out posterior to the main trunk of the pulmonary artery and supplying a small section of the posterior portion of the left upper lobe.,The specimen was delivered and sent to pathology. The mass was clearly palpable in the upper portion of the lingular portion of this left upper lobe. Frozen section showed that the margin was negative.,The chest was irrigated with warm sterile water and when the left lower lobe inflated, there was no air leak. A single 32-French chest tube was inserted, and intercostal block was done with Marcaine infiltrated two spaces above and two spaces below thus achieving a block at five levels 30 mL of Marcaine was used all together. A #2 Vicryl pericostal sutures were now applied. The serratus and latissimus muscles retracted back in place. A #19 French Blake drain placed in the subcutaneous tissues and 2-0 Vicryl used for the fat followed by 4-0 Monocryl for the skin. The patient was transferred to the ICU in a stable condition.