PROCEDURE PERFORMED: , Modified radical mastectomy.,ANESTHESIA: , General endotracheal tube.,PROCEDURE: ,After informed consent was obtained, the patient was brought to the operative suite and placed supine on the operating room table. General endotracheal anesthesia was induced without incident. The patient was prepped and draped in the usual sterile manner. Care was taken to ensure that the arm was placed in a relaxed manner away from the body to facilitate exposure and to avoid nerve injury.,An elliptical incision was made to incorporate the nipple-areolar complex and the previous biopsy site. The skin incision was carried down to the subcutaneous fat but no further. Using traction and counter-traction, the upper flap was dissected from the chest wall medially to the sternal border, superiorly to the clavicle, laterally to the anterior border of the latissimus dorsi muscle, and superolaterally to the insertion of the pectoralis major muscle. The lower flap was dissected in a similar manner down to the insertion of the pectoralis fascia overlying the fifth rib medially and laterally out to the latissimus dorsi. Bovie electrocautery was used for the majority of the dissection and hemostasis tying only the large vessels with 2-0 Vicryl. The breast was dissected from the pectoralis muscle beginning medially and progressing laterally removing the pectoralis fascia entirely. Once the lateral border of the pectoralis major muscle was identified, the pectoralis muscle was retracted medially and the interpectoral fat was removed with the specimen.,The axillary dissection was then begun by incising the fascia overlying axilla proper allowing

visualization of the axillary vein. The highest point of axillary dissection was then marked with a long stitch for identification by the surgical pathologist. The axilla was then cleared of its contents by sharp dissection. Small vessels entering the axillary vein were clipped and divided. The axilla was cleared down to the chest wall, and dissection was continued laterally to the subscapular vein. The long thoracic nerve was cleared identified lying against the chest and was carefully preserved. The long thoracic nerve represented the posterior most aspect of the dissection. As the axillary contents were dissected in the posterolateral axilla, the thoracodorsal nerve was identified and carefully preserved. The dissection continued caudally until the entire specimen was freed and delivered from the operative field. Copious water lavage was used to remove any debris, and hemostasis was obtained with Bovie electrocautery.,Two Jackson-Pratt drains were inserted through separate stab incisions below the initial incision and cut to fit. The most posterior of the 2 was directed into the axilla and the other directed anteriorly across the pectoralis major. These were secured to the skin using 2-0 silk, which was Roman-sandaled around the drain.,The skin incision was approximated with skin staples. A dressing was applied. The drains were placed on ""grenade"" suction. All surgical counts were reported as correct.,Having tolerated the procedure well, the patient was subsequently extubated and taken to the recovery room in good and stable condition.