Note From Your Admission on 08/12/21

Op Note by Daniel Ruan, MD at 8/12/2021 10:54 AM

DATE OF SERVICE: 8/12/2021

SURGEON: DANIEL RUAN, MD

ASSISTANT: none

PREOPERATIVE DIAGNOSIS: Primary hyperparathyroidism

POSTOPERATIVE DIAGNOSIS: Primary hyperparathyroidism

PROCEDURE: Parathyroidectomy, intraoperative localization of radioactive tumor

ANESTHESIA: General

ANESTHESIA STAFF: Anesthesiologist: Albrecht Wobst, MD
CRNA: Bridget Terranella Guzzardo, CRNA

ESTIMATED BLOOD LOSS: minimal

INDICATION FOR SURGERY: Kathy Mae Horn is a 75 y.o. female who presented with biochemical and symptomatic primary hyperparathyroidism. After discussing the risks, benefits, and alternatives to surgery, the patient requested a radio-guided parathyroidectomy.

FINDINGS: The patient had a parathyroid adenoma in the right upper position, which was completely excised and confirmed hyperfunctional with the radioprobe score (RPS) of 457 (normal 30 to 80). The remaining three parathyroids were normal and small biopsies were obtained from each.

DESCRIPTION OF PROCEDURE: After routine induction of anesthesia and placement of an airway without event, the patient's neck was prepped and draped. A low transverse cervical incision was made and the thyroid was exposed in the usual manner. The thyroid was atrophic. Intraoperative nuclear mapping was utilized and the parathyroid glands were identified.

The right upper parathyroid was located posterior to the mid/lower lobe. This was clearly adenomatous, and it was completely excised without capsular disruption. The RPS was 457, which is consistent with parathyroid adenoma.

The right lower parathyroid was located just caudal to the lower thyroid pole. This was a morphologically normal gland. A small biopsy was taken, and the RPS was 20.

The left upper parathyroid was located posterior to the mid/upper lobe. This was a morphologically normal gland. A small biopsy was taken, and the RPS was 10.

The left lower parathyroid was located caudal to the lower pole, in cervical thymus. This was a morphologically normal gland. A small biopsy was taken, and the RPS was 10.

We reviewed and reconciled our intraoperative findings with the patient's biochemical data and imaging results. We agreed that the chance of biochemical cure was high.

Hemostasis was excellent throughout the case. Surgicel was placed in the wound. The wound was closed in multiple layers. A single Steri-Strip was placed transversely for dressing. The patient was transferred to recovery room in stable condition.