PREOPERATIVE DIAGNOSIS: ,Carcinoma of the left upper lobe.,PROCEDURES PERFORMED:,1. Bronchoscopy with aspiration.,2. Left upper lobectomy.,PROCEDURE DETAILS: ,With patient in supine position under general anesthesia with endotracheal tube in place, the flexible bronchoscope was then placed down through the endotracheal tube to examine the carina. The carina was in the midline and sharp. Moving directly to the right side, the right upper and middle lower lobes were examined and found to be free of obstructions. Aspiration was carried out for backlog _____ examination. We then moved to left side, left upper lobe. There was a tumor mass located in the lingula of the left lobe and left lower lobe found free of obstruction. No anatomic lesions were demonstrated. The patient was prepared for left thoracotomy rotated to his right side with a double lumen endotracheal tube in place with an NG tube and a Foley catheter. After proper position, utilizing Betadine solution, they were draped. A posterolateral left thoracotomy incision was performed. Hemostasis was secured with electrocoagulation. The chest wall muscle was then divided over the sixth rib. The periosteum of the sixth rib was then removed superiorly and the pleural cavity was entered carefully. At this time, the mass was felt in the left upper lobe, which measures greater than 3 cm by palpation. We examined the superior mediastinum. No lymph nodes were demonstrated as well as in the anterior mediastinum. Direction was then moved to the fascia where by utilizing sharp and blunt dissection, lingual artery was separated into the left upper lobe. Casual dissection was

carried out with superior segmental arteries and left lower lobe was examined.,Dissection was carried out around the pulmonary artery thus exposing the posterior artery to the left upper lobe. Direction was carried out to the superior pulmonary vein and utilizing sharp and blunt dissection the entire superior pulmonary vein was separated from the surrounding tissue. From the top side, the bronchus was then separated away from the pulmonary artery anteriorly, thus exposing the apical posterior artery, which was short. Tumor mass was close to the artery at this time. We then directed ourselves once again to the lingual artery which was doubly ligated and cut free. The posterior artery of the superior branch was doubly ligated and cut free also. At this time, the bronchus of the left upper lobe was encountered in the fissure on palpation to separate the upper lobe bronchus from lower lobe bronchus and the area was accomplished. We then moved anteriorly to doubly ligate the pulmonary vein using #00 silk sutures for ligation and a transection #00 silk suture was used to fixate the vein. Using sharp and blunt dissection, the bronchus through the left upper lobe was freed proximal. Using the TA 50, the bronchus was then cut free allowing the lung to fall superiorly at which time direction was carried out to the pulmonary artery where the tumor was in close proximity at this time. A Potts clamp arterial was then placed over the artery and shaving off the tumor and the apical posterior artery was then accomplished. The anterior artery was seen in the clamp also and was separated and ligated and separated. At this time, the entire tumor in the left upper lobe

was then removed. ,Direction was carried to the suture where #000 silk was used as a running suture over the pulmonary artery and was here doubly run and tied in place. The clamp was then removed. No bleeding was seen at this time. Lymph nodes were then removed from the sump of the separation between the upper lobe and the lower lobe and sent for separate pathology. We then carried out incision in the inferior pulmonary ligament up to the pulmonary vein allowing the lung to reexpand to its normal position. At this time, two chest tubes #28 and #32 were placed anteriorly and posteriorly to fixate the skin using raw silk suture. The chest cavity was then closed. After reexamination, no bleeding was seen with three pericostal sutures of #1 chromic double strength. A #2-0 Polydek was then used to close the chest wall muscle the anterior as well as latissimus dorsi #000 chromic subcutaneous tissue skin clips to the skin. The chest tubes were attached to the Pleur-Evac drainage and placed on suction at this time. The patient was extubated in the room without difficulty and sent to Recovery in satisfactory.