Partners HealthCare System, Inc.
BRIGHAM AND WOMENS HOSPITAL
A Teaching Affiliate of Harvard Medical School
75 Francis Street, Boston, MA 02115

Operative Report

Date of Operation: 05/10/12 Report Status: Unsigned

SURGEON: SUGARBAKER, DAVID MD

ASSISTANT:
1. Marcelo DaSilva, MD
2. Brian Goodman, MD
3. Walter Lech, MD

PREOPERATIVE DIAGNOSIS:
Appendiceal carcinoma metastatic to right pleura and lung.

POSTOPERATIVE DIAGNOSIS:
Appendiceal carcinoma metastatic to right pleura and lung.

OPERATION:
Bronchoscopy, extended right thoracotomy, right extrapleural pneumonectomy, resection of central portion of the diaphragm, pericardial resection, pericardial reconstruction, diaphragmatic primary closure, radical lymph node dissection, 4, 7, 8, 9 and 10 were sampled, intercostal muscle bundle to bronchial stump.

ANESTHESIA:
General endotracheal with epidural.

INDICATIONS FOR PROCEDURE:
This is a 41-year-old woman with a history of mucinous appendiceal carcinoma with associated peritoneal carcinomatosis who is now with likely pleural spread to the right hemithorax. She has undergone a previous resection several years ago for intra-abdominal disease and there is no evidence of ascites or intra-abdominal recurrence. We have discussed the potential for pleurectomy or potential pneumonectomy. She understands the reasoning behind both of these approaches and we lean toward pleurectomy if possible. She and her husband are under the clear impression that this may not be a curative procedure.

We went through the potential risks carefully and informed consent was obtained.

DESCRIPTION OF PROCEDURE:
The patient was placed in the supine position after adequate general endotracheal anesthesia had been induced. The flexible bronchoscope was passed easily per ET tube. The right and left tracheobronchial trees were examined. There was no pus, no blood, no anatomic variation, no endobronchial lesions were noted and the scope was withdrawn.

Double lumen tube and lines were then placed by Anesthesia. The patient was placed in right thoracotomy position. The chest was opened through an extended right thoracotomy with resection of the sixth rib. We then performed a pleurectomy circumferentially to the hilar cuff and over the diaphragm where there was tumor clearly at the central tendon. The diaphragm was opened in this region and the diaphragm was resected in this area. We then noted tumor densely adherent to the ongoing pulmonary ??__?? pericardial pulmonary artery. It was determined at this time that a pleural pneumonectomy would be the only procedure that would allow us macroscopic complete resection. I scrubbed out and went and talked to her friend as well as her sister and ??__?? retained healthcare proxy. They agreed to move ahead with extrapleural pneumonectomy.

I then returned to the operating room theater. We opened the pericardium anteromedially and dissected the superior vena cava medially exposing the superior pulmonary vein and inferior vein

Operative Report

and the right main pulmonary artery. We then dissected free the right main pulmonary artery from surrounding tissues and divided utilizing the Endoleader technique with a 45 vascular stapler. The superior and inferior pulmonary veins were likewise dissected free and divided. The pericardium was then opened inferiorly and the pericardiotomy taken from inferior to superior to complete it. We then dissected free the right main bronchial stump, dividing it with a TA-30 heavy wire bronchial stapler. The specimen was removed. We then performed a radical lymphadenectomy resecting levels 4, 7, 8, 9 and 10 and sent these for pathologic inspection. The chest was then pulse lavaged with 3 L of water. Argon beam coagulation was performed in the chest and for hemostasis and tumor lysis.

The chest was then scrubbed with peroxide, 3 cycles of water and saline wash. Amifostine was then delivered and we completed a 1-hour run of 175 mg/m2 of platinum and mitomycin 0.7 mg/kg for 60 minutes. The chemo was done without difficulty and all volume was recovered. We then again checked hemostasis. We took down the intercostal muscle bundle from the fifth space and brought to the bronchial stump and tacked into the stump with interrupted 3-0 Vicryl suture. The chest was again irrigated and hemostasis was assessed. Hemostasis was noted to be adequate. A Rob-Nel catheter was then placed inferomedially to the thoracotomy and sutured in place with Ethibond sutures. The chest was then closed with #1 pericostal sutures, running layers of Vicryl in the anterior musculature and skin. Sterile dressings were applied. The patient was placed supine, awakened, extubated and taken to the ICU in stable condition.

ESTIMATED BLOOD LOSS:
400 mL.

ATTESTATION:
I, Dr. Sugarbaker, as teaching surgeon, was present for the essential components of this operation.

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Dictated By: SUGARBAKER, DAVID
Surgeon: SUGARBAKER, DAVID
Dictation ID 12412804
D: 05/17/12
T: 05/17/12

_____(DAVID JOHN SUGARBAKER, M.D.)