



Op Note signed by Thomas Trumble, MD at 10/24/2016 8:39 AM

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ADMISSION DATE: 10/21/2016

DISCHARGE DATE: 10/22/2016

CONTACT SERIAL NUMBER: 00082236631

DATE:

SURGEON: Thomas Trumble, MD

PREOPERATIVE DIAGNOSES:

1. Thoracic outlet syndrome with compression of brachial plexus
G54.02 of the left brachial plexus.
2. Compression of the long thoracic nerve from traction injury
to the scalenus medius S44.92XA.

POSTOPERATIVE DIAGNOSES:

1. Thoracic outlet syndrome with compression of brachial plexus
G54.02 of the left brachial plexus.
2. Compression of the long thoracic nerve from traction injury
to the scalenus medius S44.92XA.

OPERATION:

1. Neurolysis of brachial plexus with pressure release of
scalenus anterior and scalenus medius fascia for
decompression of thoracic outlet syndrome G64.713.
2. Decompression of long thoracic nerve 64708, both does have
complex, 0.22.

SURGEON:

Dr. Thomas Trumble and Dr. Cameron Schick.

ASSISTANT:

Derek Omori, PA-C

ANESTHESIA:

General.

PREPARATION:

Iodine paint and intravenous antibiotic.

DESCRIPTION OF PROCEDURE:

After appropriate anesthesia was obtained, the patient was prepped and draped in usual fashion in a beach chair position with the entire left upper extremity prepped and draped out free. A safety check was performed. A transverse incision was made at the level of the 2 cm superior to the clavicle. Incision was carried down through skin and subcutaneous tissue was carefully mobilized. The platysma was divided. Bleeding vessels controlled with bipolar cautery. The transverse cervical artery was identified and was able to retract it inferiorly. There was a large transversed vein communicating to the external jugular, it was controlled between 3-0 nylon stick ties. The omohyoid muscle was divided between 2-0 Vicryl ties. There was noted to be severe fibrosis and scarring of the scalenus anterior. The phrenic nerve was identified and stimulated and protected with a vessel loop. A step-cut lengthening was performed in the fascia of the scalenus anterior for decompression of thoracic outlet. In similar fashion, the fascia around the scalenus medius was encompassing the long thoracic nerve. This was stimulated. There was poor stimulation until after the fascia with a step-cut lengthening of the fascia of the scalenus medius could be performed. It was complex in detail, it was very difficult retraction. This was followed microdissection using jewelers forceps and micro-dissecting scissors. There was a dense fascia fibrosis that to be carefully peeled off the scalenus through the upper, lower and middle trunk of the brachial plexus, it was heavily encased with fascial tissue and there appeared to be spasm or rigidity of the scalenus anterior and medius. This dramatically improved, once there was lengthening of the fascia on both the scalenus anterior and scalenus medius. The stimulation demonstrated excellent contracture of distal radius following the decompression and the complex neurolysis of the brachial plexus and decompression of the long thoracic. It was once thickened cord of the fascia of scalenus medius, which could be peeled off, the long thoracic was then able to get excellent stimulation. There was also be good stimulation of the deltoid and biceps with stimulation in the upper trunk. There was noted to be improved microcirculation on the upper, middle, and lower trunks of the brachial plexus following neurolysis of the plexus and decompression. The wound was irrigated with saline and inspirations were performed. There was noted to be no evidence of any pulmonary leakage that would be consistent _____ indicating any leakage or pneumothorax. The wounds were irrigated with saline. The wound was then closed. With closure of the omohyoid with 2-0 Vicryl sutures, closure of the platysma muscle with buried 3-0 Vicryl sutures, subcutaneous layer was closed with 3-0 chromic sutures and the skin was closed with Prolene suture. Bulky dressing applied with a cervical collar. The patient was then awakened and brought to recovery room in stable condition. Derek Omari, PA-C was required to assist Dr. Trumble and Dr. Schick in his complex neurolysis of the brachial plexus with decompression with thoracic outlet syndrome and decompression of long thoracic nerve.

DICTATED BY:

Thomas Trumble, MD

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