



**BHS  
BAPTIST HEALTH SYSTEM  
SAN ANTONIO, TEXAS  
Operative Report**

PATIENT NAME _____	SEX _____	HOSPITAL <b>NEB-ASC</b>	ADMISSION NUMBER _____
ADMISSION DATE _____	DISCHARGE DATE _____	PATIENT TYPE <b>CCO</b>	LOCATION <b>NEB-ASC</b>

blushing was noted to be present as well as mild Raynaud's of the hands. Betadine prep to the anterior chest and axillae was performed with sterile drapes then being placed. Using the tip of an 11-blade, a 2 mm right axillary incision was made along the anterior axillary line, third intercostal space. The endotracheal tube was then opened to the atmosphere and a 2 mm Thoracoport was carefully inserted into the right pleural space just over the third rib. Carbon dioxide insufflation was begun thereby creating a right tension pneumothorax. Dynamic adjustment of this tension pneumothorax was done using a continuous cardiac output esophageal monitoring probe. Precise dynamic adjustment of the pleural pressure between 6 to 10 cm of pressure was done, thus optimizing exposure of the sympathetic nerve and all of its branches. A 2-mm micro-endoscope and endoshears were then inserted into the carbon dioxide cavity followed by identification of the sympathetic nerve and one Kuntz nerve crossing the right 2<sup>nd</sup>, 3<sup>rd</sup>, and 4<sup>th</sup> ribs respectively.

A right T2 sympathectomy was then performed by transecting the sympathetic nerve as it crossed the 2<sup>nd</sup> and 3<sup>rd</sup> ribs and the associated Kuntzs nerves as they crossed the 2<sup>nd</sup>, 3<sup>rd</sup>, and 4<sup>th</sup> ribs using the tip of the micro endoshears. The divided ends were then cauterized using a low setting of 15. A 14-gauge right pleural catheter was then inserted through the skin into the pleural cavity at the mid-clavicular line, third intercostal space. Paravertebral and intercostal nerve blocks were then administered by injecting 10 cc of 0.5% Ropivacaine mixed with 80 mg of Depo-Medrol onto the paravertebral regions from T2 to T4 and 5 cc of this same solution was injected into intercostal spaces 2 -4 at the axillary incision site. These blocks create a near "pain-free" state together with the single tiny operative incision, thereby affording the patient a rapid recovery to full functional status because of the near "pain-free" state achieved immediately postop. Discharge from the ambulatory surgical center after a few hours is then possible. The 14-gauge pleural catheter was attached to suction followed by re-approximation of the axillary incision using a Steri-Strip and a Band-Aid for a dressing. Upon completion of the sympathectomy, the temperature of the right middle finger had risen a few degrees centigrade.

Similar procedures were then performed on the left side with one Kuntz nerve present crossing the left 2<sup>nd</sup> rib . A left T2 sympathectomy was performed in similar fashion as on the right side. Upon completion of the left sided sympathectomy, intercostal and paravertebral blocks from T2 to T4 were given followed by re-approximation of the incision using a Steri-strip and Band-Aid for dressing.

The patient's hands became warm and dry, facial blushing resolved, a significant improvement from immediate preop. The patient tolerated the procedures well and was extubated in the operating room then transported to the Post-Anesthesia Care Unit in stable condition with warm and dry hands.

DHN/dhn \_\_\_\_\_

DD:

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David H. Nielson, MD