**Carpal Tunnel Release right**

PREOPERATIVE DIAGNOSIS: RIGHT CARPAL TUNNEL SYNDROME, SEVERE.

POSTOPERATIVE DIAGNOSIS: RIGHT CARPAL TUNNEL SYNDROME, SEVERE.

PROCEDURE: RIGHT CARPEL TUNNEL RELEASE.

SURGEON: DR. AMIT BHANDARKAR M.D.

ASSISTANT: None

COMPLICATIONS: None

SPECIMENS: None

BLOOD LOSS: Scant

IMPLANTS: None

PREOPERATIVE AREA: In the preoperative area the patient was assessed of the risks of the procedure involving injury to median nerve, injury to the palmer cutaneous branch of median nerve, palmar arch was explained to the patient. The patient understood and verbalized agreeance for the current plan of carpal tunnel release. The patient also has cervical radiculopathy and has axial neck pain with numbness especially in his index finger. It is probably coming from kind of double crush syndrome. We especially discussed with the patient about the plan for his further pain relief in the neck and arm. I think carpal tunnel is the smaller of the two surgeries. We will probably go ahead and do that today and then probably subsequently if required consider his neck as well. The patient was explained in detail what exact procedure we were going to do on him and explained about the postoperative care.

DESCRIPTION OF THE PROCEDURE: After all the explaining and getting consent from the patient, the patient was taken to the operative area where he was identified by the head nurse and the anesthetist. The patient was positioned supine on a radiolucent table with his Right arm on the side table. The patient was administered general anesthesia. The patient's IV lines were hooked up. We applied a tourniquet on the Right arm after which his Right arm was prepped and drape free. IV antibiotics of 2 grams Ancef was given to the patient. The patient's left side was again re-prepped and I was able to use and Esmarch to exsanguinate the left arm to have a bloodless field. The tourniquet pressure was then raised up to 250 and surgery was started. I had marked the incision before in the preoperative area which was on ulnar side of the palmar crease from the wrist crease on the left around 3 cm in length. The incision was carried out by drawing out a line which was me radial to the ring finger and then we abducted the thumb and then draw a line along its axis. Intersection point was then used as the incision it was the distal most point. I used a #15 blade to carry out the incision into the skin. The skin incision was deepened. There was a fatty layer subsequently which was bluntly dissected using a snap and using a long retractor. I then exposed the palmar fascia aponeurosis which I sharply incised and further dissected bluntly to expose the transverse carpal ligament. I could expose the transvers carpal ligament in its entire width. I used self-retaining retractor to hold the retraction. At this time I used the #15 blade to make the incision in the middle of the transverse carpal ligament to reach the contents of the carpal tunnel. Once reaching the depth of the carpal tunnel with the incision, I was then able to pass the freer inside the transverse carpal ligament. I then used a knife to cut the carpal tunnel ligament, distally first and then extended the dissection proximally as well. Distally I extended the incision of the transverse carpal ligament. I was then able to visualize the fat and there was complete decompression. Proximally I could continue the dissection and I also removed around 1 cm of the fascia in the forearm. The median nerve and the tendons of the carpal tunnel were completely protected with the freer throughout the procedure. After the carpal tunnel was released I was then able to inspect the tunnel by retracting the contents towards the radial side. I did not see any masses but I was able to see hourglass deformity of the median nerve confirming that this was tight median nerve. I could nicely irrigate the wound and make sure that there are no masses or inflammatory tissue causing compression of the carpal tunnel. After thorough irrigation, I could use bipolar the small bleeding in the skin. I was not able to visualize any abnormal branch of the median nerve. I used the 3-0 nylon mattress stitches to close the wound. I then dressed the wound with derma bond. I used ACE bandage to support the operative area. The patient was extubated, the tourniquet was deflated. The patient did not have much pain. The patient was taken to the recovery area. He could move his fingers and was put on elevation. His pain was reasonably being controlled. I had infiltrated the area postoperatively with Marcaine so as to give him some source of pain relief. The patient was also given a prescription for pain medication to be taken if the pain increases. I discussed with the patient about limb elevation and little finger movement after surgery. The patient should be contacting our office with any further questions or concerns.