Holy Cross Hospital
Operated by
Sisters of the Holy Cross
1045 East 1st South
Salt Lake City, Utah 84102

#2254

Family Name / First Name	Attending Physician	Room No.	Hosp. No.	Date
CHAPMAN, BRIAN	DR. A. W. MIDDLETON, JR.	206	2296382	4-7-76

OPERATION: Radical right nephrectomy with lymphadenectomy; exploration of the left kidney.

Surgeon: Dr. A. W. Middleton, Jr. LOGGED IN

Preop. Diagnosis: Right Wilms' tumor with (?) spread to the vena cava.

Postop. Diagnosis: Right Wilms' tumor with no spread to the cava. 521 76

PROCEDURE:
The patient was taken to the operating room where general anesthesia was administered. He was placed flat on his back and was prepped and draped in the standard manner. A chevron incision was used carrying the right limb farther across than the left. This was carried through all layers. We then very carefully visually inspected the liver and palpated it and found that there was nothing to suggest metastatic spread into the liver. Palpating along the great vessels failed to reveal anything suggestive of nodal spread, and we then proceeded to mobilize the hepatic flexure of the colon. We divided the peritoneum lateral to the colon and mobilized the entire thing off the tumor. We found that it came very easily with nothing to suggest spread directly from the kidney into the adjacent colon. We then carried the dissection plane over to the vena cava, kocherizing the duodenum in the process. We then very carefully dissected down the right lateral margin of the vena cava until we found the right renal vein. By means of very careful dissection we were then able to mobilize the right renal artery. Each of these in turn starting with the artery was tied with a #2-0 silk. We then carried the dissection on down to vena cava, extending it beneath the cava and over the top of the cava over as far as the aorta. As we carried the resection down onto the iliac artery and vein, we found that there was a very vascular plexus surrounding the right ureter and we ligated each of the component parts in turn and ligated the ureter after dividing this mass. We then carried the resection up the back of the right kidney, clipping or tying bleeding points when encountered. It was possible to control the blood supply on this tumor before we palpated or mobilized the kidney in any fashion. We took pains to carefully clip the lymphatics as we did our dissection down the great vessels. We then accomplished the resection by coming around the upper portion of the kidney. We used clips and cut between the clips, coming around the adrenal and the adrenal was delivered with the tumor. We doubly clamped the artery and vein and then cut between the clamps and put a suture ligature of #2-0 silk on the stump of both the vein and the artery. The tumor was then delivered from the wound. It was taken to a back table where it was cut and found to be a typical Wilms' tumor which

(continued)

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had almost totally replaced the kidney. Bleeding was completely controlled. It was necessary to place a suture of #6-0 Prolene on one bleeding point on the cava, but this controlled it nicely.

When satisfied that there was no further bleeding, we placed the colon back into its appropriate place and tacked it in place with some interrupted #4-0 silk. We then mobilized the left colon and completely stripped Gerota's fascia away from the left kidney. We were able to visualize and palpate the entire kidney and found that there was nothing to suggest tumor there.

We then placed the Georta's fascia back around the kidney and placed the left colon back in place. A nasogastric tube was passed and the position was checked in the kidney. We then closed the wound with the inner two layers of muscles closed as a single layer with interrupted #0 Ethiflex placed in a figure-of-eight fashion. The outer muscular layer was closed with a running #0 ccg. suture. The wound was irrigated with Neomycin Bacitracin following which the subcutaneous tissue was closed with running #3-0 plain and skin clips were used to close the wound. No drains were used.

The patient tolerated the procedure well and was returned to the recovery room in good condition.

521 76

A. Middleton
DR. A. W. MIDDLETON, JR.

AWM, JR:dr
Dict: 4/7
Trans: 4/8