Visit date:

Medical record 1

Inpatient

Anesthesia Record ID

Case Summary

Date:
Surgeon:
Responsible Provider: Phy A
Location:

Procedure [Code]
LAPAROSCOPY, USING VIDEO DISPLAY AND RECORDING SYSTEM (Abdomen) [49320 CPT (R)]
SIGMOIDOSCOPY (Anus) [45330 CPT (R)]
OPEN BOWEL RESECTION, COLOSTOMY (Abdomen) [44141 CPT (R)]

Diagnosis [Codes]
BOWEL OBSTRUCTION

Anesthesia & Medical History (As of Anesthesia Stop) Current as of 01/01/25 1313

Hypertension		Diabetes mellitus (CMS/HCC)	
CVA (cerebral vascular accident) (CMS/HCC)	no residual	High cholesterol	
Anesthesia	woke up during nasal surgery	Atrial flutter (CMS/HCC)	resolved
Benign neoplasm of sigmoid colon		Colon cancer (CMS/HCC)	

Surgical History (As of Anesthesia Stop) Current as of 01/01/25 1313

NASAL SEPTUM SURGERY		
ORBITAL FRACTURE SURGERY		
ABLATION A-FLUTTER	04/30/2018	Procedure: ABLATION A-FLUTTER; Laterality: N/A;
COLONOSCOPY		

Substance History (As of Anesthesia Stop) Current as of 01/01/25 1313

Smoking Status: Former

Smokeless Tobacco Status: Never

Comments: quit age 30

Alcohol use: Yes, unspecified volume

Comments: rarely

Drug use: Never

Problem List (As of Anesthesia Stop) Current as of 01/01/25 1313

CVA (cerebral vascular accident) (CMS/HCC)	Cancer of sigmoid colon (HCC)
Hyperglycemia	Thrombocytopenia (HCC)

Anesthesia BC Report

Preprocedure/Inpatient Antibiotics (last 168 hours)

Date/Time	Action	Medication	Dose	Rate
01/01/25 1700	Given	piperacillin-tazobactam (ZOSYN) 3.375 g in sodium chloride 0.9 % 100 mL IVPB (Mini-Bag Plus)	3.375 g	200 mL/hr
01/01/25 1052	New Bag	piperacillin-tazobactam (ZOSYN) 3.375 g in sodium chloride 0.9 % 100 mL IVPB (Mini-Bag Plus)	3.375 g	
12/30/24 1305	New Bag	piperacillin-tazobactam (ZOSYN) 3.375 g in sodium chloride 0.9 % 100 mL IVPB (Mini-Bag Plus)	3.375 g	
12/30/24 1057	New Bag	piperacillin-tazobactam (ZOSYN) 3.375 g in sodium chloride 0.9 % 100 mL IVPB (Mini-Bag Plus)	3.375 g	

Anesthesia Intraprocedure Medications

fentanyl (mcg)

Date/Time	Rate/Dose/Volume	Action	Admin User	Audit
01/01/25 1029	50 mcg	Given		
1112	50 mcg	Given		

lidocaine 1% (mg)

Date/Time	Rate/Dose/Volume	Action	Admin User	Audit
01/01/25 1032	40 mg	Given		

propofol (mg)

Date/Time	Rate/Dose/Volume	Action	Admin User	Audit
01/01/25 1032	150 mg	Given		

rocuronium (mg)

Date/Time	Rate/Dose/Volume	Action	Admin User	Audit
01/01/25 1032	7 mg	Given		
1043	23 mg	Given		
1112	20 mg	Given		
1152	10 mg	Given		

succinylcholine (mg)

Date/Time	Rate/Dose/Volume	Action	Admin User	Audit
01/01/25 1032	200 mg	Given		

dexamethasone 4 mg/mL (mg)

Date/Time	Rate/Dose/Volume	Action	Admin User	Audit
01/01/25 1040	4 mg	Given	Phy A MD	

ondansetron (mg)

Date/Time	Rate/Dose/Volume	Action	Admin User	Audit

Anesthesia BC Report

Anesthesia Intraprocedure Medications (continued)

01/01/25	1306	4 mg	Given	Phy A MD

phenylephrine BOLUS (mcg)

Date/Time	Rate/Dose/Volume	Action	Admin User	Audit
01/01/25 1244	150 mcg	Given	, Phy A MD	

piperacillin-tazobactam (ZOSYN) 3.375 g in sodium chloride 0.9 % 100 mL IVPB (Mini-Bag Plus) (g) Dosing weight: 92.4

Date/Time	Rate/Dose/Volume	Action	Admin User	Audit
01/01/25 1052	3.375 g (over 15 min)	New Bag	Phy A MD	

HYDROmorphone 0.5 mg/0.5 mL (mg)

Date/Time	Rate/Dose/Volume	Action	Admin User	Audit
01/01/25 1137	0.5 mg	Given	, Phy A MD	

sugammadex (mg)

Date/Time	Rate/Dose/Volume	Action	Admin User	Audit
01/01/25 1254	200 mg	Given	Phy A MD	

ROPivacaine 0.5 % (mL)

Date/Time	Rate/Dose/Volume	Action	Admin User	Audit
01/01/25 1247	20 mL (over 2 min)	Given	Phy A MD	
1251	20 mL (over 2 min)	Given	MD	

lactated ringers (LR) (mL)

Date/Time	Rate/Dose/Volume	Action	Admin User	Audit
01/01/25 1019		New Bag	Phy A MD	
1151	1,000 mL	New Bag	Phy A MD	
1254	600 mL	Anesthesia Volume Adjustment	Phy A MD	

Allergies

No Known Allergies or Adverse Reactions

Staff 01/01/25

Phy A	ANESTH	1019	1313	1

Case Tracking Events

Event	Time In
Patient In - Room	Wed Jan 1, 2025 1019
Case Start	Wed Jan 1, 2025 1021
Scope In	
Surg/Proc Start	Wed Jan 1, 2025 1053

Anesthesia BC Report

Case Tracking Events (continued)

Event	Time In
Scope Out	
Closing	
Patient on Recovery Hold	
Patient Out - Room	Wed Jan 1, 2025 1308

Events

Date	Time	Event
1/1/2025	1011	Anesthesia Evaluation Complete

16Fr OGT passed easily to 55cm. + gastric return. After suction, placed on passive drainage.
Surgeon feels post op NGT is a low chance and to proceed with OGT at this time.

1053 Procedure Start
1107 Quick Note
Converting to open procedure.
1240 Procedure Stop
1241 OG/NG Tube Removal
1245 Block Start
1253 Block Stop
1304 Extubation
1306 Stop Data Collection
1313 Anesthesia Stop
Transfer of care to PACU/ICU/RN using respective post-anesthesia transfer checklist. Patient transported to PACU awake and spontaneously ventilating without assistance or artifical airways.

Vitals 15 min Prior/10 min Post Anesthesia Stop 1/1/2025 1258 - 1/1/2025 1323

BP:	**135/106** ! arm bent	**154/101** !	173/89
Pulse:	92	92	92
Resp:	22	15	23
Temp:	37.3 °C	—	—
SpO2:	96 %	100 %	100 %

Anesthesia Information

Anesthesia Type: general, peripheral nerve block
Anesthesia Type Sub Category: inhalational GA

ASA status: 3 - Emergent

Anesthesia Positioning

	1/1/2025 1043

Anesthesia BC Report

Anesthesia Positioning (continued)

	1/1/2025
Position:	1043 Lithotomy;Arms < 90 degrees
Checklist:	Right arm tucked
Warming Device:	Forced Air
Other Warming Device:	Blanket

Assessments

	1/1/2025 1025	1/1/2025 1034	1/1/2025 1043	1/1/2025 1045
EKG:	NSR	NSR	—	NSR
Warming Device:	—	—	Forced Air	—
O2 Device:			ETT	

	1/1/2025 1100	1/1/2025 1115	1/1/2025 1130	1/1/2025 1145
EKG:	NSR	NSR	NSR	NSR
Warming Device:	—	—	—	—
O2 Device:				

	1/1/2025 1200	1/1/2025 1215	1/1/2025 1230	1/1/2025 1245
EKG:	NSR	NSR	NSR	NSR
Warming Device:	—	—	—	—
O2 Device:				

	1/1/2025
	1300
EKG:	NSR
Warming Device:	—
O2 Device:	—

Preprocedure Note

Last edited 01/01/25 1112 by
Date of Service 01/01/25 1104
Status: Signed

Anesthesia Evaluation

H&P reviewed
Existing labs reviewed
Pre-procedure vital signs reviewed

Previous Anesthesia Experience

History of anesthetic complications (hx awakening during nasal surgery per chart, pt denies problems with recent anesthetics)

Anesthesia BC Report

Preprocedure Note (continued)

Airway Mallampati: II Oral Excursion: normal TM distance: normal Neck ROM: full	**Dental** natural
Pulmonary (-) recent URI	**Cardiovascular** (+) hypertension, dysrhythmias (s/p ablation): Atrial fibrillation and atrial flutter EKG reviewed
Neuro/Psych (+) CVA,	**GI/Hepatic/Renal - negative ROS**
Endo/Other (+) diabetes	

Other findings: Resting comfortably in bed, NAD. Sensitive to motion which produces abdominal pain.

Other ROS/ Med Hx Comments: Abdominal pain POD 2, concern for anastomotic leak. 1 episode emesis with laying flat during ECG, but otherwise no N/V.

Anesthesia Plan
general and peripheral nerve block
Anesthetic plan and risks discussed with patient.

(Discussed R/B/P with patient and partner. Plan for GA with addition of TAP block if open procedure. Late entry due to direct patient care.)

ASA3 - emergent

Electronically signed by Phy A at 1/1/2025 11:12 AM

Procedure Notes

Last edited 01/01/25 1103 by
Date of Service 01/01/25 1103
Status: Signed

OR Airway Management

Anesthesia BC Report

Procedure Notes (continued)

Date/Time: **1/1/2025 10:34 AM**
Circuit: adult
Preoxygenation: Yes
Rapid Sequence: Yes
Intubation Method: video-assisted
Laryngoscope: Mac 4

ETT Location: Oral
Intubation ID: 8.0 mm
Cuff: cuffed
Stylet: Yes
Attempts: 1
Cords visualized: yes

Breath sounds: equal
ETT to lip: 25 cm
EtCO2 Detected: Yes
Dentition: teeth and oropharynx as per preoperative assessment
Procedure Difficulty: easy
Comments: **Soft bite block placed.**

Electronically signed by, Phy A, MD at 1/1/2025 11:03 AM Last edited 01/01/25 1255 by, MD
Date of Service 01/01/25 1255
Status: Signed

Peripheral Block

Patient location during procedure: OR
Start time: 1/1/2025 12:45 PM
End time: 1/1/2025 12:53 PM
Reason for block: at surgeon's request and post-op pain management

Staffing

Anesthesiologist: , Phy A MD

Preanesthetic Checklist

Completed: patient identified, site marked, surgical consent, pre-op evaluation, timeout performed, IV checked, risks and benefits discussed, monitors and equipment checked and sterile technique and prep

Peripheral Block

Patient position: supine
Prep: ChloraPrep
Patient monitoring: heart rate, continuous pulse ox and cardiac monitor
Block type: TAP
Laterality: bilateral
Techniques: ultrasound guided
Permanent ultrasound image saved in medical record: yes
Appropriate spread of the medication was noted in real time: yes
Nerve appears normal: yes
Findings: no pathologic findings

Needle

Needle type: StimuQuik
Needle gauge: 21 G

Anesthesia BC Report

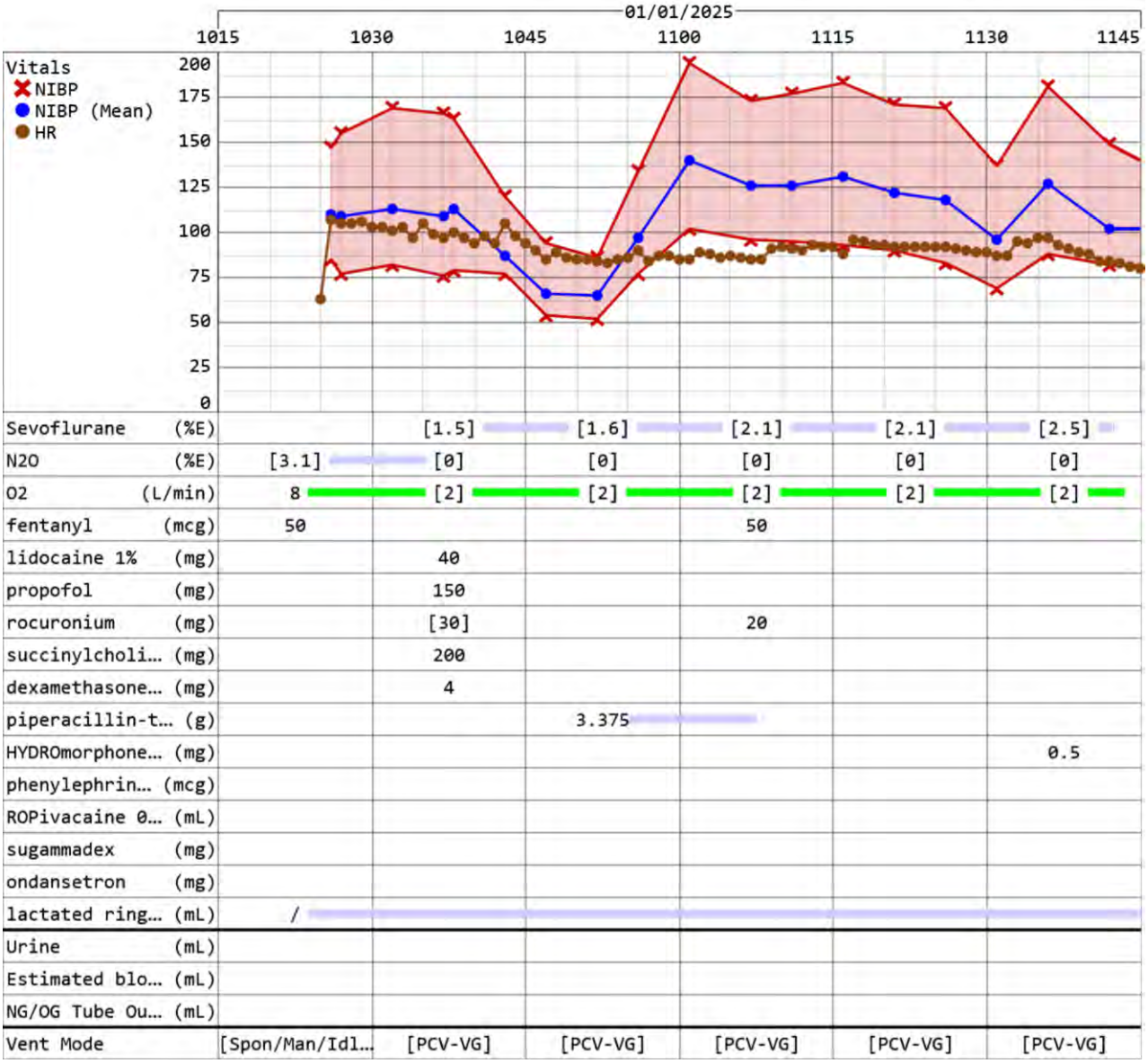
Procedure Notes (continued)

Needle length: 9 cm
Test dose: negative

Assessment

Injection assessment: negative aspiration for heme, no pain on injection and no paresthesia on injection
Heart rate change: no
Slow fractionated injection: yes
Low pressure injection: yes
Meaningful contact maintained throughout block: yes

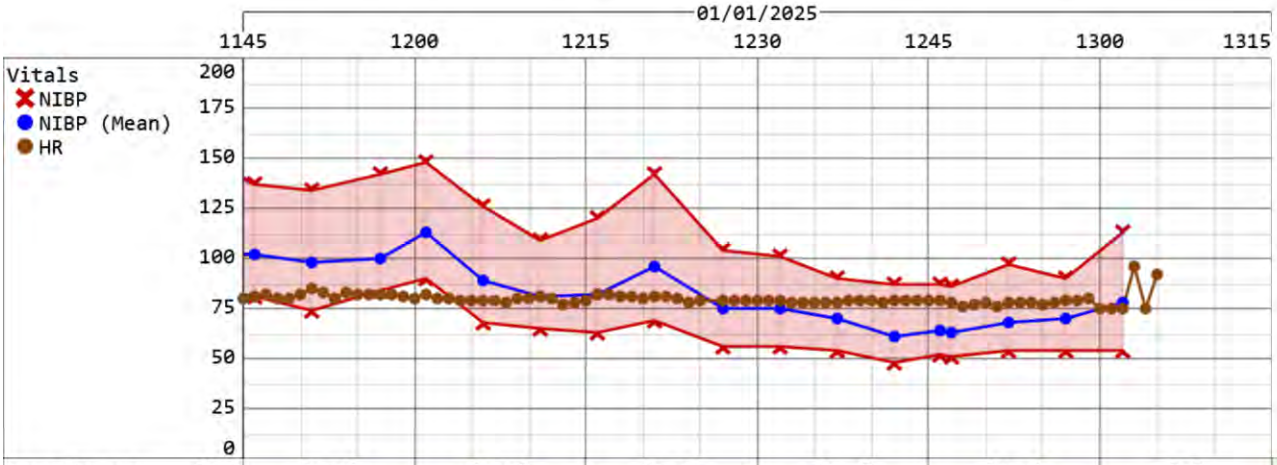
Electronically signed by, Phy A MD at 1/1/2025 12:55 PM



MRN:, DOB:, Legal Sex: M Visit date:

1/1/2025
Anesthesia BC Report

	1015	1030	1045	1100	1115	1130	1145	
Tidal (Observ… (ML)		[490]	[472]	[479]	[501]	[504]		
Resp Rate		[10]	[10]	[10]	[14]	[14]		
PEEP/CPAP (cm H2O)	5	[5]	[5]	[5]	[5]	[5]		
Mean Airwa… (cmH2O)		[9]	[13]	[12]	[12]	[13]		
Peak Airwa… (cmH2O)		[16]	[28]	[23]	[23]	[26]		
EKG	NSR	NSR	NSR	NSR	NSR	NSR		
SpO2 (%)	[96]	[99]	[99]	[99]	[99]	[100]		
ETCO2 (mmHg)		[40]	[46]	[55]	[51]	[43]		
FiO2 (%)	[39]	[97]	[97]	[96]	[96]	[96]		
Temp Source			Nasopharyngeal					
Temperature		[37.4]	[37.4]	[37.6]	[37.5]	[37.4]		



	1145	1200	1215	1230	1245	1300	1315	
Sevoflurane (%E)	[2.3]	[1.9]	[1.6]	[1.6]	[0.3]	[0]		
N2O (%E)	[0]	[0]	[0]	[0]	[0]	[0]		
O2 (L/min)	[1]	[1]	[2]	[1]	[10]	[0]		
fentanyl (mcg)								100 mcg
lidocaine 1% (mg)								40 mg
propofol (mg)								150 mg
rocuronium (mg)	10							60 mg
succinylcholi… (mg)								200 mg
dexamethasone… (mg)								4 mg
piperacillin-t… (g)								3.375 g
HYDROmorphone… (mg)								0.5 mg
phenylephrin… (mcg)				150				150 mcg
ROPivacaine 0… (mL)					[40]			40 mL
sugammadex (mg)					200			200 mg
ondansetron (mg)						4		4 mg
lactated ring… (mL)	1000				600			1600 mL
Urine (mL)				350				350 mL
Estimated blo… (mL)				150				150 mL
NG/OG Tube Ou… (mL)				25				25 mL
Vent Mode	[PCV-VG]	[PCV-VG]	[PSVpro]	[PSVpro]	[PSVpro]	[Spon/Man/Idl…		

Anesthesia BC Report

	1145	1200	1215	1230	1245	1300	1315	Totals
Tidal (Observ… (ML)	[490]	[507]	[424]	[471]	[602]	[691]		
Resp Rate	[14]	[14]	[16]	[16]	[13]	[2]		
PEEP/CPAP (cm H2O)	[5]	[5]	[5]	[5]	[5]	[5]		
Mean Airwa… (cmH2O)	[13]	[12]	[9]	[9]	[8]	[1]		
Peak Airwa… (cmH2O)	[25]	[25]	[16]	[16]	[12]	[28]		
EKG	NSR	NSR	NSR	NSR	NSR	NSR		
SpO2 (%)	[100]	[99]	[99]	[99]	[100]	[100]		
ETCO2 (mmHg)	[43]	[41]	[41]	[38]	[35]	[43]		
FiO2 (%)	[96]	[97]	[97]	[97]	[100]	[100]		
Temp Source								
Temperature	[37.5]	[37.5]	[37.5]	[37.4]	[37.3]			

All Postprocedure Notes

Last edited 01/01/25 1759 by, Phy A MD
Date of Service 01/01/25 1759
Status: Signed

Post-Anesthesia Evaluation Note

01/01/25
5:59 PM

Scott M Church

Vitals	Value	Taken Time
BP	168/90	01/01/25 1500
Pulse	102	01/01/25 1510
Temp	37 °C	01/01/25 1500
Resp	18	01/01/25 1510
SpO2	94 %	01/01/25 1510

Vitals shown include unfiled device data.

Vital signs in patient's normal range:Yes
Respiratory function stable; airway patent:Yes
Cardiovascular function and hydration status stable:Yes
Mental status recovered; patient participates in evaluation:Yes
Pain control satisfactory:Yes
Nausea and vomiting control satisfactory: Yes

Receiving long-acting(>48 hrs) regional anesthesia: No

Patient anticipated to be unable to participate in evaluation within 48hrs:No

Additional Comments: none

Electronically signed by, Phy A, MD at 1/1/2025 5:59 PM

All Postprocedure Notes (continued)

All Follow Up Notes

No postoperative notes have been written.

Attestation Information

None

Encounter Status

Signed By Phy A on 1/1/25 at 18:00

Addendum Information

No notes found.

Brief Op Note - Notes

Brief Op Note by, Phy A MD at 1/1/2025 1:09 PM

Author:, MD | Service: Surgery | Author Type:
Filed: 1/1/2025 1:11 PM | Date of Service: 1:09 PM | Status: Cosign Needed

Editor:, MD (Resident) **Brief Operative Note**

Patient : ; 65 y.o. **MRN#**
Room:
Admit Date: 12/30/2024
Attending: Phy C

The identity of the patient was confirmed and a bedside time out was performed. See complete operative note for full details.

Date	1/1/2025
Post-op diagnosis	Bowel ischemia
Procedure	Procedure(s): LAPAROSCOPY, USING VIDEO DISPLAY AND RECORDING SYSTEM SIGMOIDOSCOPY OPEN BOWEL RESECTION, COLOSTOMY
Surgeon	Surgeons and Role: *, MD – Phy A,Primary
Assistant(s)	Circulator:, RN

Specimen(s)			Time
[redacted]	Sigmoid [redacted]	G	[redacted]

Brief Op Note - Notes (continued)

Brief Op Note by, Phy B, MD at 1/1/2025 1:09 PM (continued)

	anastomosis	, Sigmoid Colon	PATHOLOGY EXAM	, MD

Findings	Ischemic appearing bowel proximal to previous anastomosis No purulence or feculent material noted See full operative report[EH.1]

Attribution Key

EH.1 -, Phy A, MD on 1/1/2025 1:09 PM

Brief Op Note by, MD at 12/30/2024 3:48 PM

Author:, Phy A, MD | Service: Surgery | Author Type: Resident
Filed: 12/30/2024 3:49 PM | Date of Service: 12/30/2024 3:48 PM | Status: Signed
Editor:, MD (Resident)

Brief Operative Note

Cosigner: MD at 12/30/2024 3:53 PM

Patient :; 65 y.o. **MRN#**
Room: BED
Admit Date: 12/30/2024
Attending:, Phy B, MD

The identity of the patient was confirmed and a bedside time out was performed. See complete operative note for full details.

Date	12/30/2024
Post-op diagnosis	Sigmoid adenocarcinoma
Procedure	Procedure(s): RESECTION, SIGMOID, LAPAROSCOPIC, ERAS
Surgeon	Surgeons and Role: *, Phy B, MD - Primary
Assistant(s)	Circulator:, RN Relief Circulator:,RN 1 RN;, RN Relief Scrub:, RN 2, , ST Scrub :, ST
Anesthesiologist(s)	Resident:, MD Anesthesiologist: Phy A III, MD
Anesthesia type	

[redacted]

Brief Op Note - Notes (continued)

Brief Op Note by, Phy B, MD at 12/30/2024 3:48 PM (continued)

Estimated blood loss	General * No values recorded between 12/30/2024 10:36 AM and 12/30/2024 3:48 PM *
Specimen(s)	ID: 1 : SIGMOID COLON; Type: Tissue; Source: Large Intestine, Sigmoid Colon; Tests: SURGICAL PATHOLOGY EXAM; Collected by: , MD; Time: 12/30/2024 1420 ID: 2 : PROXIMAL ANASTAMOTIC DONUT; Type: Tissue; Source: Large Intestine, Sigmoid Colon; Tests: SURGICAL PATHOLOGY EXAM; Collected by: , MD; Time: 12/30/2024 1444 ID: 3 : DISTAL ANASTAMOTIC DONUT; Type: Tissue; Source: Large Intestine, Sigmoid Colon; Tests: SURGICAL PATHOLOGY EXAM; Collected by: , MD; Time: 12/30/2024 1444
Findings	Small mass in distal sigmoid colon See operative report for further findings[EH.1]

Attribution Key

EH.1 -, MD on 12/30/2024 3:48 PM

[redacted]

Op Note - Notes

Op Note filed by, Phy B, MD at 1/1/2025 1:51 PM / Draft: Not Electronically Signed

Author:, MD | Service: Surgery | Author Type: Physician
Filed: 1/1/2025 1:51 PM | Date of Service: 1/1/2025 12:00 AM | Status: Unsigned Transcription
Editor:, MD (Physician)

Patient:
MR#:
Date of Operation: 01/01/2025
Location:
DOB: 11/04/1959 Sex: M
Surgeon: Phy B , MD
Physician: Phy A , MD

OPERATIVE REPORT

SURGEON:
Phy B, MD

ASSISTANT:
ASST 1, , MD, PGY-2

PREOPERATIVE DIAGNOSIS:
Anastomotic leak.

POSTOPERATIVE DIAGNOSIS:
Anastomotic leak.

OPERATION:
Laparoscopy, open resection of the anastomosis with end colostomy.

ANESTHESIA:
General endotracheal.

ANESTHESIOLOGIST:
Phy A, MD

INDICATIONS:
The patient is a 65-year-old man who two days ago had a laparoscopic sigmoid resection for a colon cancer. This morning, he has diffuse abdominal pain and tenderness with tachycardia and hypertension. He is passing dark bloody material from the rectum.

FINDINGS:
Laparoscopy revealed ischemia of the bowel just proximal to the anastomosis. The procedure was converted to an open procedure. There was some blood in the abdomen, but no succuss or stool. The abdomen was thoroughly explored, and no other source of his problems was found. There was no evidence of injury to any piece of bowel. The anastomosis was tested by filling the pelvis with saline and insufflating air into the rectum until the bowel proximal distended. No air leak was found, but the bowel did appear ischemic. A rigid sigmoidoscopy showed the distal rectum right up to the anastomosis to be healthy and pink. Just proximal to the anastomosis, the mucosa with dark and dusky consistent with ischemia and even necrosis. The decision was made to resect the ischemic portion of the bowel and do an end colostomy.

PROCEDURE:
The patient was taken to the operating room and placed on the operative room table. General endotracheal anesthesia was administered. A Foley catheter was placed. The patient was placed in the Allen stirrups. The patient's abdomen was

Op Note - Notes (continued)

Op Note filed by, Phy B, MD at 1/1/2025 1:51 PM / Draft: Not Electronically Signed (continued)

prepped and draped in sterile fashion. A timeout was performed according to AAMC protocol. Local anesthetic used was 0.25 percent Marcaine with 1:200,000 parts epinephrine. This was injected into the epigastric area.

An incision was made through the prior incision, and a 5-mm port was placed into the peritoneal cavity with no difficulty. The abdomen was insufflated with carbon dioxide. The abdomen was inspected. There was no purulent material, succuss or fecal material seen. No fibrinous exudate was seen. There was some dark blood.

Local anesthetic was given in the infraumbilical area. A small incision was made through the prior incision, and a 5-mm port was placed under direct visualization. With this to allow for retraction, the anastomosis could be better visualized. The bowel just proximal to the anastomosis was clearly ischemic with a line of demarcation seen about 5 cm proximal. A leak test was then performed by filling the pelvis with saline and insufflating air into the rectum. No air bubbles were seen.

Rigid sigmoidoscopy was then performed. The bowel just distal to the anastomosis was healthy and pink. Proximal to the anastomosis, the bowel was dark and dusky consistent with severe ischemia and even necrosis. The decision was made that he was clearly having a bacterial translocation and that this anastomosis was going to fail.

The abdomen was then thoroughly explored to assure there was no other source of the patient's symptoms. There was no evidence of any enterotomy despite running the entire small bowel. There was no fibrinous exudate, fecal material or succuss seen elsewhere in the bowel. The colon, as much as it could be examined, was healthy. It was clear that the problem was with the anastomosis.

The rectum just distal to the anastomosis was cleaned off of fat. The fat was divided using electrocautery. The rectum was then divided just distal to the anastomosis using a Contour stapler with a green cartridge. A second firing was required for the final 1 cm of the bowel.

An ellipse of skin in the left lower quadrant was removed just over the rectus muscle. The subcutaneous tissue was divided. The anterior rectus sheath was opened in a cruciate fashion. The rectus muscle was split. The posterior sheath and peritoneum were opened up in a cruciate fashion. Attention was turned to the proximal bowel.

The point of demarcation was identified, and the bowel was cleaned off from its mesentery just proximal to this. The mesentery was divided. Hemostasis was maintained using Vicryl ties and electrocautery. The bowel with then amputated using another firing of the Contour stable with a blue cartridge. The staple line was then brought up through the hole in the abdominal wall to create the colostomy. This reached with no tension.

The midline fascia was closed using a running #1 double-stranded PDS suture. The wounds were irrigated. The skin incisions were closed using staples. The colostomy was then matured in a Brooke fashion using interrupted 3-0 Vicryl sutures. The colostomy was healthy without any tension. An ostomy appliance and dressing were applied.

The patient tolerated the procedure well. A TAP block was performed by the anesthesiologist. The patient was taken to the recovery room extubated and stable.

ESTIMATED BLOOD LOSS:
100 mL.

SGP/one/81041//174/2012318/DD: 01/01/2025 12:49/DT: 01/01/2025 13:46

cc: , MD, PGY-2
[SP.1]

Attribution Key
SP.1 -, MD on 1/1/2025 1:51 PM

Op Note - Notes (continued)

Op Note filed by, Phy B, MD at 1/1/2025 1:51 PM / Draft: Not Electronically Signed (continued)

Op Note filed by, Phy B, MD at 12/30/2024 3:52 PM / Draft: Not Electronically Signed

Author:, MD | Service: Surgery | Author Type: Physician
Filed: 12/30/2024 3:52 PM | Date of Service: 12/30/2024 12:00 AM | Status: Unsigned Transcription
Editor:, MD (Physician)

Patient:
MR#:
Date of Operation: 12/30/2024
Location:
DOB: 11/04/1959 Sex: M
Surgeon: , Phy B, MD
Physician: Phy A, MD

OPERATIVE REPORT

SURGEON:
Phy B, , MD

ASSISTANT:

PREOPERATIVE DIAGNOSIS:
Sigmoid cancer.

POSTOPERATIVE DIAGNOSIS:
Sigmoid cancer.

OPERATION:
Laparoscopic sigmoid resection, mobilization of the splenic flexure, intraoperative ultrasound.

ANESTHESIA:
General endotracheal.

ANESTHESIOLOGIST:
Phy A, MD.

INDICATIONS:
The patient is a 65-year-old man who on a routine colonoscopy was found to have a mass in the sigmoid colon. This was tattooed distally. Pathology showed adenocarcinoma, MMR proficient. He now presents for a resection.

FINDINGS:
Intraoperative ultrasound showed one of the cysts seen on CT scan, but no evidence of metastases. The tattoo was seen a couple of centimeters above the peritoneal reflection, and the tumor was found 2-3 cm proximal to the tattoo. A laparoscopic sigmoid resection was performed with a primary stapled anastomosis. The splenic flexure was mobilized.

PROCEDURE:
The patient was taken to the operating room and placed on the operating room table. General endotracheal anesthesia was administered. A Foley catheter was placed. The patient was placed in the Allen stirrups. The patient's rectum was irrigated with saline followed by diluted Betadine. The patient's abdomen and perianal area were prepped and draped in sterile fashion. A timeout was performed according to AAMC protocol. Local anesthetic used was 0.25 percent Marcaine with 1:200,000 parts epinephrine. This was injected into the infraumbilical area. A small incision was made. The umbilical plate was elevated. Under direct visualization with constant insufflation, a 5 mm port was placed into the peritoneal cavity.

Op Note - Notes (continued)

Op Note filed by, Phy B, MD at 12/30/2024 3:52 PM / Draft: Not Electronically Signed (continued)

Local anesthetic was given in the epigastric area. An incision was made, and a 5 mm port was placed under direct visualization. Local anesthetic was given in the right lower quadrant. An incision was made, and a 10 mm port was placed under direct visualization. Later on in the case, for better exposure, local anesthetic was given in the right upper quadrant. An incision was made, and a 5 mm port was placed under direct visualization.

The abdomen was inspected. The tattoo was seen 2-3 cm above the peritoneal reflection. The cancer could be palpated 2-3 cm above this. There was no evidence of metastases.

The liver was carefully inspected and appeared normal. All visible surfaces were examined with the endoscopic ultrasound. One of the cysts seen on CT scan was seen in the right lobe of the liver not too far from the diaphragm. This was small and clearly cystic. No other abnormalities were seen on the intraoperative ultrasound.

The descending colon was mobilized by incising along the white line of Toldt. This was taken up and around the splenic flexure. The distal transverse colon was separated from the omentum entering the lesser sac. This dissection was then continued across and around. Hemostasis was maintained with the LigaSure device. In this way, the splenic flexure was fully mobilized.

The dissection was continued down towards the pelvis on the left side. The left ureter was identified and kept out of harm's way. The dissection was then done medially. This met up with the lateral dissection. Hemostasis was maintained with the LigaSure device. The major vessels were then divided using the Echelon Flex 60 stapler with a gray cartridge. Care was taken the ureter was not injured. the dissection was then continued down into the pelvis on the left and the right side. A portion of the top of the rectum was chosen well distal to the tattoo and well distal to the cancer to allow for at least a 5 cm margin. In this area, the mesorectum was separated from the rectum. The mesorectum was divided with the LigaSure device. The bowel was then divided using the Echelon Flex 60 stapler with a blue cartridge. A second firing was required for the last centimeter.

Local anesthetic was then given in the suprapubic area. A standard Pfannenstiel incision was made. A wound protector was used. The bowel was brought through the wound protector. A portion of the distal sigmoid colon was chosen. This would easily reach down into the pelvis. It was well away from the cancer. It was healthy and would allow for an adequate nodal harvest. The bowel was separated from its mesentery. The mesentery was divided with the LigaSure device. The bowel was then amputated and sent to pathology. It was bleeding from the amputated end, indicating a good blood supply. Sizers were placed, and the large sizer fit with no difficulty, and ECS 29 stapler was chosen. The anvil was placed into the bowel. The bowel was closed using another firing of the Echelon Flex 60 stapler with a blue cartridge. A small enterotomy was created next to the bowel. The shaft of the anvil was brought through this. The area was reinforced with a 3-0 Vicryl purse string suture. The bowel was placed back into the abdomen. The staple was placed via the anus up to the rectal staple line. The spike was brought out just anterior to the staple line. The stapler was put back together and closed. There was no twisting of the bowel. There was no tension. The stapler was then fired. Two complete donuts were found and sent as proximal and distal donuts. The anastomosis was then tested by filling the pelvis with warm saline and insufflating air into the rectum until the bowel proximal to the anastomosis clearly distended. There were no air bubbles. The irrigation was then suctioned out. A TAP block was performed bilaterally with a total of 30 ml of local anesthetic. The 10 mm port site fascia was then closed using 0 Vicryl with the Endo Close device. The abdomen was desufflated. The peritoneum of the Pfannenstiel incision was closed with a running 0 Vicryl suture. The fascia was closed using a 2-0 PDS suture. The wounds were irrigated. The skin incisions were all closed using 4-0 Monocryl subcuticular stitches. Exofin was used as a dressing. The patient tolerated the procedure well and was taken to the recovery room in stable condition.

ESTIMATED BLOOD LOSS:
150 ml.

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cc:
[SP.1]

Attribution Key

Anesthesia BC Report

Op Note - Notes (continued)

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