PROTOCOLE OPERATOIRE / OPERATIVE REPORT

Site: MCH Date: 2023-10-25 20:39

Anesthésiste / Anesthetist: Dr. Claire Dubois
Chirurgien / Surgeon: Dr. Marie-Claire Dubois
Assistant(s): Dr. resident John Paul

Diagnostic préopératoire / Pre-operative diagnosis:
APPENDICITIS WITH BOWEL OBSTRUCTION.
Diagnostic postopératoire / Post-operative diagnosis:
GANGRENOUS APPENDICITIS.

Opération / Operation:
APPENDECTOMY WITH REMOVAL OF APPENDICOLITH.

Tissu envoyé en pathologie / Tissue sent to pathology: Appendix and mesoappendix
Anesthésie / Anesthesia: General anesthesia with nitrous oxide

Historique et constatations opératoires / History and operative findings:

A 7-year-old non-binary who presented with abdominal pain with palpable mass. Initially evaluated 1 days prior and diagnosed with gastroesophageal reflux. Now has markedly elevated WBC, elevated CRP, high fever. Imaging: ultrasound reporting lymphadenopathy.

Procédure(s) opératoire(s) / Operative procedure(s):

Patient in supine position. General anesthesia with caudal block administered. Time-out was performed and abdomen prepped in sterile fashion. A vertical infraumbilical incision is made and carried down to the fascia which is incised sharply. We place two additional trocars, one in the suprapubic region and one in the left lower quadrant, both under direct vision. No iatrogenic injuries occurred during trocar placement. Upon entering the abdominal cavity, moderate adhesions noted. The surgical field demonstrated distended appendix with marked surrounding inflammation. Abscess cavity found in RLQ and irrigated. Minimal adhesions were noted. Blunt dissection is used to free the appendix from surrounding structures. We dissect the mesentery of the appendix and use the electrocautery to coagulate the artery. The base of the appendix is healthy and we place three EndoLoops - two proximal and one distal - before transecting the appendix. Specimen placed in EndoCatch bag for removal. Copious irrigation is undertaken to ensure removal of all inflammatory debris. The umbilical fascia is reapproximated with interrupted Vicryl 2-0 sutures. Skin incisions are closed with non-absorbable Prolene 4-0.

Monitor for signs of infection; advance diet as tolerated. The patient tolerated the procedure well with minimal blood loss.