PROTOCOLE OPERATOIRE / OPERATIVE REPORT

Site: Hopital Pierre-Boucher Date: 2024-05-07 05:19

Anesthésiste / Anesthetist: Dr. Kevin Zhang
Chirurgien / Surgeon: Dr. Olivia Davis
Assistant(s): Dr. resident Jennifer Park

Diagnostic préopératoire / Pre-operative diagnosis:
PHLEGMONOUS APPENDICITIS.
Diagnostic postopératoire / Post-operative diagnosis:
GANGRENOUS APPENDICITIS.

Opération / Operation:
APPENDECTOMY WITH REMOVAL OF APPENDICOLITH.

Tissu envoyé en pathologie / Tissue sent to pathology: Appendix and inflamed tissue
Anesthésie / Anesthesia: General anesthesia with mask induction

Historique et constatations opératoires / History and operative findings:

A 4-year-old non-binary who presented with RLQ tenderness and guarding. Initially evaluated 2 days prior and diagnosed with gastroenteritis. Now has markedly elevated WBC, high CRP, no fever. Imaging: MRI showing bowel wall thickening.

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

Patient in supine position. General endotracheal anesthesia administered. Time-out was performed and abdomen prepped in sterile fashion. Incision is made in left lower quadrant for open conversion. Accessory port placed in epigastric region. No iatrogenic injuries occurred during trocar placement. Upon entering the abdominal cavity, diffuse adhesions noted. Findings include thick-walled appendix with mild inflammatory changes. A moderate amount of purulent material was present in the pelvis. Fibrinous adhesions were lysed during the procedure. No technical difficulties encountered during surgery. We carefully dissect the inflammatory mass and identify the gangrenous appendix. The mesoappendix is divided using a bipolar energy device. We apply an endoscopic stapler to the base of the appendix and divide it. Specimen placed in EndoCatch bag for removal. Copious irrigation is undertaken to ensure removal of all inflammatory debris. We close the fascia at the umbilical port with figure-of-eight sutures of PDS 2-0 and the skin with Dermabond.

We will continue current antibiotic regimen and begin enteral feeds when bowel function returns. The patient tolerated the procedure well with minimal blood loss.