PROTOCOLE OPERATOIRE / OPERATIVE REPORT

Site: CHU Sainte-Justine Date: 2024-07-25 10:20

Anesthésiste / Anesthetist: Dr. Paul Anderson
Chirurgien / Surgeon: Dr. Sarah Johnson
Assistant(s): Dr. resident Fatima Sheikh

Diagnostic préopératoire / Pre-operative diagnosis:
PHLEGMONOUS APPENDICITIS.
Diagnostic postopératoire / Post-operative diagnosis:
APPENDICITIS WITH EXTENSIVE ADHESIONS.

Opération / Operation:
LAPAROSCOPIC APPENDECTOMY WITH IRRIGATION AND DRAINAGE.

Tissu envoyé en pathologie / Tissue sent to pathology: Appendix with attached omentum
Anesthésie / Anesthesia: Total intravenous anesthesia

Historique et constatations opératoires / History and operative findings:

A 10-year-old female who presented with abdominal pain with diarrhea. Initially evaluated 2 days prior and diagnosed with intussusception. Now has markedly elevated WBC, high CRP, low-grade fever. Imaging: ultrasound showing phlegmonous appendicitis.

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

Patient in supine position. General anesthesia with mask induction administered. Time-out was performed and abdomen prepped in sterile fashion. Transverse infraumbilical incision is performed and access gained via blunt dissection. Supplementary ports are placed in the suprapubic area and left iliac fossa. No iatrogenic injuries occurred during trocar placement. Upon entering the abdominal cavity, extensive adhesions noted. Operative findings included ruptured appendix and extensive inflammation. No abscess was identified. Fibrinous adhesions were lysed during the procedure. No intraoperative complications occurred. Blunt dissection is used to free the appendix from surrounding structures. Mesenteric vessels to the appendix are secured prior to removal. Endoscopic stapling is used for appendiceal division. Specimen placed in EndoCatch bag for removal. Saline is used for thorough irrigation of all quadrants. We close the fascia at the umbilical port with figure-of-eight sutures of Maxon 2-0 and the skin with non-absorbable Prolene 4-0.

We will continue current antibiotic regimen and begin enteral feeds when bowel function returns. No need for drains postoperatively. The patient tolerated the procedure well with minimal blood loss.