PROTOCOLE OPERATOIRE / OPERATIVE REPORT

Site: Ste-Agathe Hospital Date: 2024-06-04 01:13

Anesthésiste / Anesthetist: Dr. David Smith

Chirurgien / Surgeon: Dr. Sarah Johnson

Assistant(s): Dr. resident Fatima Sheikh

Diagnostic préopératoire / Pre-operative diagnosis:

PERFORATED APPENDICITIS.

Diagnostic postopératoire / Post-operative diagnosis:

APPENDICITIS WITH EXTENSIVE ADHESIONS.

Opération / Operation:

OPEN APPENDECTOMY.

Tissu envoyé en pathologie / Tissue sent to pathology: Appendix

Anesthésie / Anesthesia: Total intravenous anesthesia

Historique et constatations opératoires / History and operative findings:

A 1-year-old male who presented with abdominal pain and constipation. Initially evaluated 3 days prior and diagnosed with urinary tract infection. Now has normal WBC, normal CRP, low-grade fever. Imaging: MRI showing bowel wall thickening.

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. We create a 1 cm infraumbilical incision and enter the abdomen using the Hasson technique. 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, minimal adhesions noted. Operative findings included suppurative appendix and diffuse inflammation. Purulent fluid was noted throughout the abdominal cavity. Severe adhesions required careful lysis. Incidental Meckel's diverticulum found and left in situ. Blunt dissection is used to free the appendix from surrounding structures. The appendiceal mesentery is carefully taken down with harmonic scalpel. Base of appendix secured with purse-string suture prior to removal. Specimen placed in EndoCatch bag for removal. Irrigation performed with antibiotic solution. Umbilical port site is closed with Maxon 2-0 and skin with Steri-Strips. Small serosal tear repaired intraoperatively.

Monitor for signs of infection; advance diet as tolerated. No need for drains postoperatively. The patient tolerated the procedure well with minimal blood loss.