

PROTOCOLE OPERATOIRE / OPERATIVE REPORT

Site: Hopital Charles-LeMoyne

Date: 2025-06-09 17:07

Anesthésiste / Anesthetist: Dr. Michael Brown

Chirurgien / Surgeon: Dr. Sarah Johnson

Assistant(s): Dr. resident Jake Turner

Diagnostic préopératoire / Pre-operative diagnosis:

APPENDICITIS WITH FREE FLUID.

Diagnostic postopératoire / Post-operative diagnosis:

PHLEGMONOUS APPENDICITIS.

Opération / Operation:

LAPAROSCOPIC APPENDECTOMY WITH DRAINAGE OF ABSCESS.

Tissu envoyé en pathologie / Tissue sent to pathology: Appendix and abscess wall

Anesthésie / Anesthesia: General anesthesia and epidural block

Historique et constatations opératoires / History and operative findings:

15-year-old male with one week abdominal pain, normal WBC, elevated CRP, high fever. Imaging: ultrasound reporting lymphadenopathy. history of constipation. Past medical history is otherwise unremarkable.

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. Transverse infraumbilical incision is performed and access gained via blunt dissection. Accessory port placed in epigastric region. No iatrogenic injuries occurred during trocar placement. Upon entering the abdominal cavity, extensive adhesions noted. Intraoperative examination revealed thick-walled appendix. No abscess was identified. The appendix was adhered to surrounding structures. The surrounding tissues showed fluctuating reaction. No evidence of malignancy. Dissection is carried out to isolate the base of the appendix. The mesoappendix is divided using a bipolar energy device. Base of appendix secured with purse-string suture prior to removal. Specimen placed in EndoCatch bag for removal. Thorough irrigation of the abdominal cavity is performed, removing all purulent material. We close the fascia at the umbilical port with figure-of-eight sutures of PDS 2-0 and the skin with interrupted nylon 4-0.

We will continue current antibiotic regimen and begin enteral feeds when bowel function returns. No technical difficulties encountered during surgery. The patient tolerated the procedure well with minimal blood loss.

Case ID: CASE-47200M-12816