PROTOCOLE OPERATOIRE / OPERATIVE REPORT

Site: Children's Hospital Date: 2024-01-08 16:59

Anesthésiste / Anesthetist: Dr. John Evans
Chirurgien / Surgeon: Dr. Robert Tremblay
Assistant(s): Dr. resident Sophia Lee

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

Opération / Operation:
LAPAROSCOPIC APPENDECTOMY WITH OMENTAL WRAPPING.

Tissu envoyé en pathologie / Tissue sent to pathology: Appendicolith
Anesthésie / Anesthesia: General anesthesia with mask induction

Historique et constatations opératoires / History and operative findings:

A 10-year-old male with one week history of abdominal pain with distention. Failed conservative management for IBD. Imaging: CT scan showing appendiceal abscess. Past medical history is otherwise unremarkable.

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

Patient in supine position. General anesthesia administered. Time-out was performed and abdomen prepped in sterile fashion. Incision is made in left lower quadrant for open conversion. Two working ports are established in the right and left lower quadrants. No iatrogenic injuries occurred during trocar placement. Upon entering the abdominal cavity, significant adhesions noted. The surgical field demonstrated perforated appendix with localized surrounding inflammation. A large pelvic abscess was present and evacuated. Dense adhesions were encountered during dissection. Minor bleeding controlled with cautery. Meticulous dissection performed due to distorted anatomy. Mesenteric vessels to the appendix are secured prior to removal. 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. We lavage the abdomen extensively, paying particular attention to the pelvis and right gutter. The umbilical fascia is reapproximated with interrupted PDS 2-0 sutures. Skin incisions are closed with interrupted nylon 4-0. No need for drains postoperatively.

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