PROTOCOLE OPERATOIRE / OPERATIVE REPORT

Site: Royal Victoria Hospital Date: 2025-07-22 15:41

Anesthésiste / Anesthetist: Dr. Camille Roy
Chirurgien / Surgeon: Dr. Aisha Patel
Assistant(s): Dr. resident Emily Clark

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

Opération / Operation:
LAPAROSCOPIC CONVERTED TO OPEN APPENDECTOMY.

Tissu envoyé en pathologie / Tissue sent to pathology: Appendix and mesoappendix
Anesthésie / Anesthesia: General anesthesia with local infiltration

Historique et constatations opératoires / History and operative findings:

Patient (2 years, male) presented with abdominal pain with diarrhea, markedly elevated WBC, high CRP. Imaging: MRI showing bowel wall thickening.

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

Patient in supine position. General anesthesia with local infiltration administered. Time-out was performed and abdomen prepped in sterile fashion. A small infraumbilical incision is made and the abdominal cavity is entered under direct vision. 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, extensive adhesions noted. Findings include friable appendix with moderate inflammatory changes. No abscess was identified. The omentum was wrapped around the inflamed appendix. Ovaries and uterus normal in female patients. We carefully dissect the inflammatory mass and identify the ruptured appendix. 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. Thorough irrigation of the abdominal cavity is performed, removing all purulent material. The umbilical fascia is reapproximated with interrupted Vicryl 2-0 sutures. Skin incisions are closed with subcuticular Monocryl 4-0.

Early ambulation and supportive care recommended. The patient tolerated the procedure well with minimal blood loss.