PROTOCOLE OPERATOIRE / OPERATIVE REPORT

Site: Jewish General Hospital Date: 2024-09-23 14:29

Anesthésiste / Anesthetist: Dr. Camille Roy
Chirurgien / Surgeon: Dr. Victor Chen
Assistant(s): Dr. resident Jake Turner

Diagnostic préopératoire / Pre-operative diagnosis:
RUPTURED APPENDICITIS.
Diagnostic postopératoire / Post-operative diagnosis:
ACUTE APPENDICITIS.

Opération / Operation:
OPEN APPENDECTOMY WITH PELVIC LAVAGE.

Tissu envoyé en pathologie / Tissue sent to pathology: Appendix with attached omentum
Anesthésie / Anesthesia: General anesthesia with caudal block

Historique et constatations opératoires / History and operative findings:

12-year-old non-binary with one week abdominal pain. Treated for IBD; symptoms persisted. Imaging: ultrasound with non-visualized appendix and secondary signs.

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. We make an infraumbilical incision of 1 cm, dissect the subcutaneous tissue bluntly and penetrate the abdominal cavity via an open technique. Supplementary ports are placed in the suprapubic area and left iliac fossa. No iatrogenic injuries occurred during trocar placement. Upon entering the abdominal cavity, minimal adhesions noted. Appendix appeared distended, surrounded by diffuse inflammatory reaction. A moderate amount of purulent material was present in the pelvis. Severe adhesions required careful lysis. Bladder and ureters visualized, no injury. Appendix is isolated after adhesiolysis. We dissect the mesentery of the appendix and use the electrocautery to coagulate the artery. 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. Abdominal lavage performed until clear. Fascial closure is performed at the umbilical site using PDS 3-0. The skin is closed with non-absorbable Prolene 4-0. Small serosal tear repaired intraoperatively.

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