PROTOCOLE OPERATOIRE / OPERATIVE REPORT

Site: Hopital Charles-LeMoyne Date: 2025-03-19 20:25

Anesthésiste / Anesthetist: Dr. Camille Roy
Chirurgien / Surgeon: Dr. Marie-Claire Dubois
Assistant(s): Dr. resident Carlos Mendez

Diagnostic préopératoire / Pre-operative diagnosis:
PERFORATED APPENDICITIS.
Diagnostic postopératoire / Post-operative diagnosis:
APPENDICITIS WITH PERITONEAL CONTAMINATION.

Opération / Operation:
OPEN APPENDECTOMY WITH PELVIC LAVAGE.

Tissu envoyé en pathologie / Tissue sent to pathology: Appendix and abscess wall
Anesthésie / Anesthesia: General anesthesia with mask induction

Historique et constatations opératoires / History and operative findings:

A 14-year-old male who presented with abdominal pain with diarrhea. Initially evaluated 1 days prior and diagnosed with constipation. Now has markedly elevated WBC, high CRP, low-grade fever. Imaging: CT scan confirming appendicitis.

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

Patient in supine position. General anesthesia and epidural block 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. Additional 5 mm trocars are placed in the right and left lower quadrants under laparoscopic guidance. No iatrogenic injuries occurred during trocar placement. Upon entering the abdominal cavity, extensive adhesions noted. The surgical field demonstrated sclerotic appendix with persistent surrounding inflammation. Abscess cavity found in RLQ and irrigated. The omentum was wrapped around the inflamed appendix. No mesenteric ischemia. Blunt dissection is used to free the appendix from surrounding structures. The appendiceal mesentery is carefully taken down with harmonic scalpel. We apply an endoscopic stapler to the base of the appendix and divide it. 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 Polysorb 2-0 and the skin with subcuticular Vicryl 4-0.

We will continue current antibiotic regimen and begin enteral feeds when bowel function returns. Incidental Meckel's diverticulum found and left in situ. The patient tolerated the procedure well with minimal blood loss.