PROTOCOLE OPERATOIRE / OPERATIVE REPORT

Site: MCH Date: 2023-10-17 22:25

Anesthésiste / Anesthetist: Dr. David Smith

Chirurgien / Surgeon: Dr. Paul Lambert

Assistant(s): Dr. resident Maya Singh

Diagnostic préopératoire / Pre-operative diagnosis:

APPENDICITIS WITH ABSCESS.

Diagnostic postopératoire / Post-operative diagnosis:

APPENDICITIS WITH LOCALIZED PERITONITIS.

Opération / Operation:

APPENDECTOMY WITH REMOVAL OF APPENDICOLITH.

Tissu envoyé en pathologie / Tissue sent to pathology: Appendix and inflamed tissue

Anesthésie / Anesthesia: General anesthesia with caudal block

Historique et constatations opératoires / History and operative findings:

17-year-old non-binary with 1 day abdominal pain, elevated WBC, high CRP, low-grade fever. Imaging: ultrasound showing perforated appendicitis. recent antibiotic use.

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 create a 1 cm infraumbilical incision and enter the abdomen using the Hasson technique. 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, diffuse adhesions noted. Operative findings included hyperemic appendix and localized inflammation. A moderate amount of purulent material was present in the pelvis. Multiple bowel loops adherent to the mass. Small serosal tear repaired intraoperatively. Appendix is isolated after adhesiolysis. The appendiceal mesentery is carefully taken down with harmonic scalpel. Absorbable ligatures are applied prior to amputation. Specimen placed in EndoCatch bag for removal. We irrigate the abdominal cavity copiously with warm saline until the effluent is clear. We close the fascia at the umbilical port with figure-of-eight sutures of PDS 3-0 and the skin with subcuticular Monocryl 4-0.

Early ambulation and supportive care recommended. No mesenteric ischemia. The patient tolerated the procedure well with minimal blood loss.