PROTOCOLE OPERATOIRE / OPERATIVE REPORT

Site: CHU Sainte-Justine Date: 2024-05-30 07:18

Anesthésiste / Anesthetist: Dr. Paul Anderson
Chirurgien / Surgeon: Dr. Daniel Fortin
Assistant(s): Dr. resident Chloe Nguyen

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

Opération / Operation:
OPEN APPENDECTOMY.

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

Historique et constatations opératoires / History and operative findings:

A 6-year-old non-binary who presented with abdominal pain and constipation. Initially evaluated 2 days prior and diagnosed with Crohn's disease. Now has markedly elevated WBC, normal CRP, no fever. Imaging: ultrasound showing perforated appendicitis.

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. Direct trocar insertion after skin and fascia incision. Accessory port placed in epigastric region. No iatrogenic injuries occurred during trocar placement. Upon entering the abdominal cavity, minimal adhesions noted. Operative findings included suppurative appendix and extensive inflammation. A small localized abscess was found and drained. Dense adhesions were encountered during dissection. No technical difficulties encountered during surgery. Meticulous dissection performed due to distorted anatomy. The appendiceal artery is ligated and divided. We apply an endoscopic stapler to the base of the appendix and divide it. Specimen placed in EndoCatch bag for removal. We irrigate the abdominal cavity copiously with warm saline until the effluent is clear. The umbilical fascia is reapproximated with interrupted Polysorb 2-0 sutures. Skin incisions are closed with subcuticular Monocryl 4-0.

Patient to receive postoperative IV antibiotics with monitoring for return of bowel function. No mesenteric ischemia. The patient tolerated the procedure well with minimal blood loss.