PROTOCOLE OPERATOIRE / OPERATIVE REPORT

Site: MCH Date: 2024-11-12 09:21

Anesthésiste / Anesthetist: Dr. David Smith
Chirurgien / Surgeon: Dr. Ahmed Khan
Assistant(s): Dr. resident Sophia Lee

Diagnostic préopératoire / Pre-operative diagnosis:
PERFORATED APPENDICITIS.
Diagnostic postopératoire / Post-operative diagnosis:
APPENDICITIS WITH MESENTERIC LYMPHADENITIS.

Opération / Operation:
OPEN APPENDECTOMY WITH PELVIC LAVAGE.

Tissu envoyé en pathologie / Tissue sent to pathology: Appendicolith
Anesthésie / Anesthesia: Total intravenous anesthesia

Historique et constatations opératoires / History and operative findings:

Pediatric patient (4, female) presenting with acute onset abdominal pain and constipation. History: family history of appendicitis. Imaging confirmed appendicitis. Past medical history is otherwise unremarkable.

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

Patient in supine position. General anesthesia with nitrous oxide administered. Time-out was performed and abdomen prepped in sterile fashion. Transverse infraumbilical incision is performed and access gained via blunt dissection. 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, moderate adhesions noted. Intraoperative examination revealed necrotic appendix. A moderate amount of purulent material was present in the pelvis. Multiple bowel loops adherent to the mass. The surrounding tissues showed marked reaction. Patient tolerated procedure well. Dissection is carried out to isolate the base of the appendix. We dissect the mesentery of the appendix and use the electrocautery to coagulate the artery. The appendix is ligated at its base with two absorbable sutures and then amputated. Specimen placed in EndoCatch bag for removal. Copious irrigation is undertaken to ensure removal of all inflammatory debris. We close the fascia at the umbilical port with figure-of-eight sutures of Ethibond 2-0 and the skin with Steri-Strips. No technical difficulties encountered during surgery.

Postoperative imaging if fever persists. The patient tolerated the procedure well with minimal blood loss.