PROTOCOLE OPERATOIRE / OPERATIVE REPORT

Site: CHU Sainte-Justine Date: 2025-02-26 15:56

Anesthésiste / Anesthetist: Dr. John Evans
Chirurgien / Surgeon: Dr. Sophie Chen
Assistant(s): Dr. resident Sophia Lee

Diagnostic préopératoire / Pre-operative diagnosis:
LOCALIZED PERITONITIS SECONDARY TO APPENDICITIS.
Diagnostic postopératoire / Post-operative diagnosis:
LOCALIZED PERITONITIS SECONDARY TO APPENDICITIS.

Opération / Operation:
LAPAROSCOPIC APPENDECTOMY WITH DRAINAGE OF ABSCESS.

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

Historique et constatations opératoires / History and operative findings:

A 14-year-old non-binary who presented with abdominal pain with palpable mass. Initially evaluated 2 days prior and diagnosed with gastroenteritis. Now has elevated WBC, normal CRP, no fever. Imaging: ultrasound suggestive of 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. We make an infraumbilical incision of 1 cm, dissect the subcutaneous tissue bluntly and penetrate the abdominal cavity via an open technique. Two working ports are established in the right and left lower quadrants. No iatrogenic injuries occurred during trocar placement. Upon entering the abdominal cavity, diffuse adhesions noted. Intraoperative examination revealed acutely inflamed appendix. There was a contained abscess in the right lower quadrant. The appendix was adhered to surrounding structures. The surrounding tissues showed diffuse reaction. Minimal intraoperative blood loss. Blunt dissection is used to free the appendix from surrounding structures. The mesoappendix is divided using a bipolar energy device. Absorbable ligatures are applied prior to amputation. Specimen placed in EndoCatch bag for removal. Saline is used for thorough irrigation of all quadrants. The umbilical fascia is reapproximated with interrupted Maxon 2-0 sutures. Skin incisions are closed with subcuticular Vicryl 4-0.

Monitor wound sites for infection. Small serosal tear repaired intraoperatively. The patient tolerated the procedure well with minimal blood loss.