PROTOCOLE OPERATOIRE / OPERATIVE REPORT

Site: CHU Sainte-Justine Date: 2024-09-18 06:57

Anesthésiste / Anesthetist: Dr. Amélie Moreau
Chirurgien / Surgeon: Dr. Olivia Davis
Assistant(s): Dr. resident Carlos Mendez

Diagnostic préopératoire / Pre-operative diagnosis:
RUPTURED APPENDICITIS.
Diagnostic postopératoire / Post-operative diagnosis:
APPENDICITIS WITH LOCALIZED PERITONITIS.

Opération / Operation:
LAPAROSCOPIC CONVERTED TO OPEN APPENDECTOMY.

Tissu envoyé en pathologie / Tissue sent to pathology: Appendix and peri-appendiceal tissue
Anesthésie / Anesthesia: General anesthesia with caudal block

Historique et constatations opératoires / History and operative findings:

A 8-year-old female who presented with abdominal pain with fever. Initially evaluated 2 days prior and diagnosed with urinary tract infection. Now has elevated WBC, elevated CRP, high fever. Imaging: ultrasound showing appendicitis. Past medical history is otherwise unremarkable.

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

Patient in supine position. General anesthesia with caudal block administered. Time-out was performed and abdomen prepped in sterile fashion. A vertical infraumbilical incision is made and carried down to the fascia which is incised sharply. Three trocars in total are used for laparoscopic access. No iatrogenic injuries occurred during trocar placement. Upon entering the abdominal cavity, significant adhesions noted. The surgical field demonstrated necrotic appendix with minimal surrounding inflammation. There was a contained abscess in the right lower quadrant. Multiple bowel loops adherent to the mass. Small serosal tear repaired intraoperatively. Surrounding omentum and bowel are separated from the inflammatory mass. We dissect the mesentery of the appendix and use the electrocautery to coagulate the artery. Base of appendix secured with purse-string suture prior to removal. Specimen placed in EndoCatch bag for removal. Abdominal lavage performed until clear. The umbilical fascia is reapproximated with interrupted Ethibond 2-0 sutures. Skin incisions are closed with non-absorbable Prolene 4-0.

We will continue current antibiotic regimen and begin enteral feeds when bowel function returns. The patient tolerated the procedure well with minimal blood loss.