PROTOCOLE OPERATOIRE / OPERATIVE REPORT

Site: CHU Sainte-Justine Date: 2024-01-21 17:57

Anesthésiste / Anesthetist: Dr. Rachel Stein

Chirurgien / Surgeon: Dr. Ahmed Khan

Assistant(s): Dr. resident John Paul

Diagnostic préopératoire / Pre-operative diagnosis:

RUPTURED APPENDICITIS.

Diagnostic postopératoire / Post-operative diagnosis:

APPENDICITIS WITH PELVIC ABSCESS.

Opération / Operation:

OPEN APPENDECTOMY WITH PELVIC LAVAGE.

Tissu envoyé en pathologie / Tissue sent to pathology: Appendix with surrounding lymph nodes

Anesthésie / Anesthesia: General anesthesia

Historique et constatations opératoires / History and operative findings:

A 10-year-old non-binary who presented with abdominal pain with elevated WBC. Initially evaluated 2 days prior and diagnosed with mesenteric adenitis. Now has normal WBC, elevated CRP, no fever. Imaging: ultrasound showing appendicitis.

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

Patient in supine position. General anesthesia with mask induction administered. Time-out was performed and abdomen prepped in sterile fashion. Direct trocar insertion after skin and fascia incision. 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. Appendix was acutely inflamed and surrounded by Multiple small abscesses were encountered. and No significant adhesions. No bowel injury noted. Blunt dissection is used to free the appendix from surrounding structures. The appendiceal mesentery is carefully taken down with harmonic scalpel. We apply an endoscopic stapler to the base of the appendix and divide it. Specimen placed in EndoCatch bag for removal. Thorough irrigation of the abdominal cavity is performed, removing all purulent material. We close the fascia at the umbilical port with figure-of-eight sutures of Vicryl 3-0 and the skin with subcuticular Monocryl 4-0. Small serosal tear repaired intraoperatively.

IV fluids and pain management as per protocol. No mesenteric ischemia. The patient tolerated the procedure well with minimal blood loss.