PREOPERATIVE DIAGNOSIS: , Appendicitis.,POSTOPERATIVE DIAGNOSIS:, Appendicitis. ,PROCEDURE: , Laparoscopic appendectomy. ,ANESTHESIA: , General with endotracheal intubation. ,PROCEDURE IN DETAIL: ,The patient was taken to the operating room and placed supine on the operating room table. General anesthesia was administered with endotracheal intubation. His abdomen was prepped and draped in a standard, sterile surgical fashion. A Foley catheter was placed for bladder decompression. Marcaine was injected into his umbilicus. A small incision was made. A Veress needle was introduced in his abdomen. CO2 insufflation was done to a maximum pressure of 15 mmHg and a 12-mm VersaStep port was placed through his umbilicus. A 5-mm port was then placed just to the right side of the umbilicus. Another 5-mm port was placed just suprapubic in the midline. Upon inspection of the cecum, I was able find an inflamed and indurated appendix. I was able to clear the mesentery at the base of the appendix between the appendix and the cecum. I fired a white load stapler across the appendix at its base and fired a grey load stapler across the mesentery, and thereby divided the mesentery and freed the appendix. I put the appendix in an Endocatch bag and removed it through the umbilicus. I irrigated out the abdomen. I then closed the fascia of the umbilicus with interrupted 0 Vicryl suture utilizing Carter-Thomason and closed the skin of all incisions with a running Monocryl. Sponge, instrument, and needle counts were correct at the

end of the case. The patient tolerated the procedure well without any complications.