PROCEDURE:,: After informed consent was obtained, the patient was brought to the operating room and placed supine on the operating room table. General endotracheal anesthesia was induced. The patient was then prepped and draped in the usual sterile fashion. An #11 blade scalpel was used to make a small infraumbilical skin incision in the midline. The fascia was elevated between two Ochsner clamps and then incised. A figure-of-eight stitch of 2-0 Vicryl was placed through the fascial edges. The 11-mm port without the trocar engaged was then placed into the abdomen. A pneumoperitoneum was established. After an adequate pneumoperitoneum had been established, the laparoscope was inserted. Three additional ports were placed all under direct vision. An 11-mm port was placed in the epigastric area. Two 5-mm ports were placed in the right upper quadrant. The patient was placed in reverse Trendelenburg position and slightly rotated to the left. The fundus of the gallbladder was retracted superiorly and laterally. The infundibulum was retracted inferiorly and laterally. Electrocautery was used to carefully begin dissection of the peritoneum down around the base of the gallbladder. The triangle of Calot was carefully opened up. The cystic duct was identified heading up into the base of the gallbladder. The cystic artery was also identified within the triangle of Calot. After the triangle of Calot had been carefully dissected, a clip was then placed high up on the cystic duct near its junction with the gallbladder. The cystic artery was clipped twice proximally and once distally. Scissors were then introduced and used to make a small ductotomy in the cystic duct, and

the cystic artery was divided. An intraoperative cholangiogram was obtained. This revealed good flow through the cystic duct and into the common bile duct. There was good flow into the duodenum without any filling defects. The hepatic radicals were clearly visualized. The cholangiocatheter was removed, and two clips were then placed distal to the ductotomy on the cystic duct. The cystic duct was then divided using scissors. The gallbladder was then removed up away from the liver bed using electrocautery. The gallbladder was easily removed through the epigastric port site. The liver bed was then irrigated and suctioned. All dissection areas were inspected. They were hemostatic. There was not any bile leakage. All clips were in place. The right gutter up over the edge of the liver was likewise irrigated and suctioned until dry. All ports were then removed under direct vision. The abdominal cavity was allowed to deflate. The fascia at the epigastric port site was closed with a stitch of 2-0 Vicryl. The fascia at the umbilical port was closed by tying the previously placed stitch. All skin incisions were then closed with subcuticular sutures of 4-0 Monocryl and 0.25% Marcaine with epinephrine was infiltrated into all port sites. The patient tolerated the procedure well. The patient is currently being aroused from general endotracheal anesthesia. I was present during the entire case.