PREOPERATIVE DIAGNOSIS: , Acute appendicitis.,POSTOPERATIVE DIAGNOSIS:, Acute suppurative appendicitis.,PROCEDURE PERFORMED: , Laparoscopic appendectomy.,ANESTHESIA: , General endotracheal and Marcaine 0.25% local.,INDICATIONS:, This 29-year-old female presents to ABCD General Hospital Emergency Department on 08/30/2003 with history of acute abdominal pain. On evaluation, it was noted that the patient has clinical findings consistent with acute appendicitis. However, the patient with additional history of loose stools for several days prior to event. Therefore, a CAT scan of the abdomen and pelvis was obtained revealing findings consistent with acute appendicitis. There was no evidence of colitis on the CAT scan. With this in mind and the patient's continued pain at present, the patient was explained the risks and benefits of appendectomy. She agreed to procedure and informed consent was obtained.,GROSS FINDINGS: , The appendix was removed without difficulty with laparoscopic approach. The appendix itself noted to have a significant inflammation about it. There was no evidence of perforation of the appendix.,PROCEDURE DETAILS:, The patient was placed in supine position. After appropriate anesthesia was obtained and sterile prep and drape completed, a #10 blade scalpel was used to make a curvilinear infraumbilical incision. Through this incision, a Veress needle was utilized to create a CO2 pneumoperitoneum of 15 mmHg. The Veress needle was then removed. A 10 mm trocar was then introduced through this incision into the abdomen. A video laparoscope

was then inserted and the above noted gross findings were appreciated upon evaluation. Initially, bilateral ovarian cysts were appreciated, however, there was no evidence of acute disease on evaluation. Photodocumentation was obtained.,A 5 mm port was then placed in the right upper quadrant. This was done under direct visualization and a blunt grasper was utilized to mobilize the appendix. Next, a 12 mm port was placed in the left lower quadrant lateral to the rectus musculature under direct visualization. Through this port, the dissector was utilized to create a small window in the mesoappendix. Next, an EndoGIA with GI staples was utilized to fire across the base of the appendix, which was done noting it to be at the base of the appendix. Next, staples were changed to vascular staples and the mesoappendix was then cut and vessels were then ligated with vascular staples. Two 6 X-loupe wires with EndoGIA were utilized in this prior portion of the procedure. Next, an EndoCatch was placed through the 12 mm port and the appendix was placed within it. The appendix was then removed from the 12 mm port site and taken off the surgical site. The 12 mm port was then placed back into the abdomen and CO2 pneumoperitoneum was recreated. The base of the appendix was reevaluated and noted to be hemostatic. Aspiration of warm saline irrigant then done and noted to be clear. There was a small adhesion appreciated in the region of the surgical site. This was taken down with blunt dissection without difficulty. There was no evidence of other areas of disease. Upon re-exploration with a video laparoscope in the abdomen and after this noting the

appendix base to be hemostatic and intact. The instruments were removed from the patient and the port sites were then taken off under direct visualization. The CO2 pneumoperitoneum was released into the air and the fascia was approximated in the 10 mm and 12 mm port sites with #0 Vicryl ligature x2. Marcaine 0.25% was then utilized in all three incision sites and #4-0 Vicryl suture was used to approximate the skin and all three incision sites. Steri-Strips and sterile dressings were applied. The patient tolerated the procedure well and taken to Postoperative Care Unit in stable condition and monitored under General Medical Floor on IV antibiotics, pain medications, and return to diet.