PREOPERATIVE DIAGNOSIS: , Right lower quadrant abdominal pain, rule out acute appendicitis.,POSTOPERATIVE DIAGNOSIS:, Acute suppurative appendicitis.,PROCEDURE PERFORMED:,1. Diagnostic laparoscopy.,2. Laparoscopic appendectomy.,ANESTHESIA: , General endotracheal and injectable 1% lidocaine and 0.25% Marcaine.,ESTIMATED BLOOD LOSS: , Minimal.,SPECIMEN: , Appendix.,COMPLICATIONS: , None.,BRIEF HISTORY: , This is a 37-year-old Caucasian female presented to ABCD General Hospital with progressively worsening suprapubic and right lower quadrant abdominal pain, which progressed throughout its course starting approximately 12 hours prior to presentation. She admits to some nausea associated with it. There have been no fevers, chills, and/or genitourinary symptoms. The patient had right lower quadrant tenderness with rebound and percussion tenderness in the right lower quadrant. She had a leukocytosis of 12.8. She did undergo a CT of the abdomen and pelvis, which was non diagnostic for an acute appendicitis. Given the severity of her abdominal examination and her persistence of her symptoms, we recommend the patient undergo diagnostic laparoscopy with probable need for laparoscopic appendectomy and possible open appendectomy. The risks, benefits, complications of the procedure, she gave us informed consent to proceed.,OPERATIVE FINDINGS: ,Exploration of the abdomen via laparoscopy revealed an appendix with suppurative fluid surrounding it, it was slightly enlarged. The

left ovary revealed some follicular cysts. There was no evidence of adnexal masses and/or torsion of the fallopian tubes. The uterus revealed no evidence of mass and/or fibroid tumors. The remainder of the abdomen was unremarkable.,OPERATIVE PROCEDURE: , The patient was brought to the operative suite, placed in the supine position. The abdomen was prepped and draped in the normal sterile fashion with Betadine solution. The patient underwent general endotracheal anesthesia. The patient also received a preoperative dose of Ancef 1 gram IV. After adequate sedation was achieved, a #10 blade scalpel was used to make an infraumbilical transverse incision utilizing a Veress needle. Veress needle was inserted into the abdomen and the abdomen was insufflated approximately 15 mmHg. Once the abdomen was sufficiently insufflated, a 10 mm bladed trocar was inserted into the abdomen without difficulty. A video laparoscope was inserted into the infraumbilical trocar site and the abdomen was explored. Next, a 5 mm port was inserted in the midclavicular line of the right upper quadrant region. This was inserted under direct visualization. Finally, a suprapubic 12 mm portal was created. This was performed with #10 blade scalpel to create a transverse incision. A bladed trocar was inserted into the suprapubic region. This was done again under direct visualization. Maryland dissector was inserted into the suprapubic region and a window was created between the appendix and mesoappendix at the base of the cecum. This was done while the 5 mm trocar was used to grasp the middle portion of the appendix and retracted

anteriorly. Utilizing a endovascular stapling device, the appendix was transected and doubly stapled with this device. Next, the mesoappendix was doubly stapled and transected with the endovascular stapling device. The staple line was visualized and there was no evidence of bleeding. The abdomen was fully irrigated with copious amounts of normal saline. The abdomen was then aspirated. There was no evidence of bleeding. All ports were removed under direct visualization. No evidence of bleeding from the port sites. The infraumbilical and suprapubic ports were then closed. The fascias were then closed with #0-Vicryl suture on a UR6 needle. Once the fascias were closed, all incisions were closed with #4-0 undyed Vicryl. The areas were cleaned, Steri-Strips were placed across the wound. Sterile dressing was applied.,The patient tolerated the procedure well. She was extubated following the procedure, returned to Postanesthesia Care Unit in stable condition. She will be admitted to General Medical Floor and she will be followed closely in the early postoperative course.