PREOPERATIVE DIAGNOSIS:, Cecal polyp.,POSTOPERATIVE DIAGNOSIS: , Cecal polyp.,PROCEDURE: , Laparoscopic resection of cecal polyp.,COMPLICATIONS: , None., ,ANESTHESIA: ,General oral endotracheal intubation.,PROCEDURE:, After adequate general anesthesia was administered the patient's abdomen was prepped and draped aseptically. Local anesthetic was infiltrated into the right upper quadrant where a small incision was made. Blunt dissection was carried down to the fascia which was grasped with Kocher clamps. A bladed 11-mm port was inserted without difficulty. Pneumoperitoneum was obtained using C02. Under direct vision 2 additional, non-bladed, 11-mm trocars were placed, one in the left lower quadrant and one in the right lower quadrant. There was some adhesion noted to the anterior midline which was taken down using the harmonic scalpel. The cecum was visualized and found to have tattoo located almost opposite the ileocecal valve. This was in what appeared to be an appropriate location for removal of this using the Endo GIA stapler without impinging on the ileocecal valve or the appendiceal orifice. The appendix was somewhat retrocecal in position but otherwise looked normal. The patient was also found to have ink marks in the peritoneal cavity diffusely indicating possible extravasation of dye. There was enough however in the wall to identify the location of the polyp. The lesion was grasped with a Babcock clamp and an Endo GIA stapler used to fire across this transversely. The specimen was then removed through the 12-mm port and examined on the back table. The

lateral margin was found to be closely involved with the specimen so I did not feel that it was clear. I therefore lifted the lateral apex of the previous staple line and created a new staple line extending more laterally around the colon. This new staple line was then opened on the back table and examined. There was some residual polypoid material noted but the margins this time appeared to be clear. The peritoneal cavity was then lavaged with antibiotic solution. There were a few small areas of bleeding along the staple line which were treated with pinpoint electrocautery. The trocars were removed under direct vision. No bleeding was noted. The bladed trocar site was closed using a figure-of-eight O Vicryl suture. All skin incisions were closed with running 4-0 Monocryl subcuticular sutures. Mastisol and Steri-Strips were placed followed by sterile Tegaderm dressing. The patient tolerated the procedure well without any complications.