

PREOPERATIVE DIAGNOSIS:, Acute  
appendicitis.,POSTOPERATIVE DIAGNOSES:,1. Pelvic  
inflammatory disease.,2. Periappendicitis.,PROCEDURE  
PERFORMED:,1. Laparoscopic appendectomy.,2. Peritoneal  
toilet and photos.,ANESTHESIA:  
,General.,COMPLICATIONS: , None.,ESTIMATED BLOOD  
LOSS:, Less than 10 cc.,INDICATIONS FOR PROCEDURE: ,  
The patient is a 31-year-old African-American female who  
presented with right lower quadrant abdominal pain presented  
with acute appendicitis. She also had mild leukocytosis with  
bright blood cell count of 12,000. The necessity for diagnostic  
laparoscopy was explained and possible appendectomy. The  
patient is agreeable to proceed and signed preoperatively  
informed consent.,PROCEDURE: , The patient was taken to  
the operative suite and placed in the supine position under  
general anesthesia by Anesthesia Department.,The  
preoperative Foley, antibiotics, and NG tube are placed for  
decompression and the anterior abdominal wall was prepped  
and draped in the usual sterile fashion and infraumbilical  
incision is performed with a #10 blade scalpel with anterior  
and superior traction on the abdominal wall. A Veress needle  
was introduced and 15 mm pneumoperitoneum is created  
with CO2 insufflation. At this point, the Veress needle was  
removed and a 10 mm trocar is introduced intraperitoneally. A  
second 5 mm port was introduced in the right upper quadrant  
under direct visualization and blunt graspers were  
introduced to bring the appendix into view. With the aid of a  
laparoscope, the pelvis was visualized. The ovaries are

brought in views and photos are taken. There is evidence of a purulence in the cul-de-sac and \_\_\_\_\_ with a right ovarian hemorrhagic cyst. Attention was then turned on the right lower quadrant. The retrocecal appendix is freed with peritoneal adhesions removed with Endoshears. Attention was turned to the suprapubic area. The 12 mm port was introduced under direct visualization and the mesoappendix was identified. A 45 mm endovascular stapling device was fired across the mesoappendix and the base of the appendix sequentially with no evidence of bleeding or leakage from the staple line. Next, \_\_\_\_\_ tube was used to obtain Gram stain and cultures of the pelvic fluid and a pelvic toilet was performed with copious irrigation of sterile saline. Next, attention was turned to the right upper quadrant. There is evidence of adhesions from the liver surface to the anterior abdominal wall consistent with Fitz-Hugh-Curtis syndrome also a prior pelvic inflammatory disease. All free fluid is aspirated and patient's all port sites are removed under direct visualization and the appendix is submitted to pathology for final pathology. Once the ports are removed the pneumoperitoneum is allowed to escape for patient's postoperative comfort and two larger port sites at the suprapubic and infraumbilical sites are closed with #0 Vicryl suture on a UR-6 needle. Local anesthetic is infiltrated at L3 port sites for postoperative analgesia and #4-0 Vicryl subcuticular closure is performed with undyed Vicryl. Steri-Strips are applied along with sterile dressings. The patient was awakened from anesthesia without difficulty and transferred to recovery room with postoperative

broad-spectrum IV antibiotics in the General Medical Floor.  
Routine postoperative care will be continued on this patient.