PREOPERATIVE DIAGNOSIS: , Left adrenal mass, 5.5 cm.,POSTOPERATIVE DIAGNOSES:,1. Left adrenal mass, 5.5 cm.,2. Intraabdominal adhesions.,PROCEDURE PERFORMED:,1. Laparoscopic lysis of adhesions.,2. Laparoscopic left adrenalectomy.,ANESTHESIA: , General.,ESTIMATED BLOOD LOSS:, Less than 100 cc.,FLUIDS: , 3500 cc crystalloids.,DRAINS:, None.,DISPOSITION:, The patient was taken to recovery room in stable condition. Sponge, needle, and instrument counts were correct per OR staff.,HISTORY:, This is a 57-year-old female who was found to have a large left adrenal mass, approximately 5.5 cm in size. She had undergone workup previously with my associate, Dr. X as well as by Endocrinology, and showed this to be a nonfunctioning mass. Due to the size, the patient was advised to undergo an adrenalectomy and she chose the laparoscopic approach due to her multiple pulmonary comorbidities.,INTRAOPERATIVE FINDINGS: , Showed multiple intraabdominal adhesions in the anterior abdominal wall. The spleen and liver were unremarkable. The gallbladder was surgically absent.,There was large amount of omentum and bowel in the pelvis, therefore the gynecological organs were not visualized. There was no evidence of peritoneal studding or masses. The stomach was well decompressed as well as the bladder.,PROCEDURE DETAILS: , After informed consent was obtained from the patient, she was taken to the operating room and given general anesthesia. She was placed on a bean bag and secured to the table. The table was rotated to

the right to allow gravity to aid in our retraction of the bowel.,Prep was performed. Sterile drapes were applied. Using the Hassan technique, we placed a primary laparoscopy port approximately 3 cm lateral to the umbilicus on the left. Laparoscopy was performed with _____. At this point, we had a second trocar, which was 10 mm to 11 mm port. Using the non-cutting trocar in the anterior axillary line and using Harmonic scalpel, we did massive lysis of adhesions from the anterior abdominal wall from the length of the prior abdominal incision, the entire length of the abdominal incision from the xiphoid process to the umbilicus. The adhesions were taken down off the entire anterior abdominal wall.,At this point, secondary and tertiary ports were placed. We had one near the midline in the subcostal region and to the left midline and one at the midclavicular line, which were also 10 and 11 ports using a non-cutting blade.,At this point, using the Harmonic scalpel, we opened the white line of Toldt on the left and reflected the colon medially, off the anterior aspect of the Gerota's fascia. Blunt and sharp dissection was used to isolate the upper pole of the kidney, taking down some adhesions from the spleen. The colon was further mobilized medially again using gravity to aid in our retraction. After isolating the upper pole of the kidney using blunt and sharp dissection as well as the Harmonic scalpel, we were able to dissect the plane between the upper pole of the kidney and lower aspect of the adrenal gland. We were able to isolate the adrenal vein, dumping into the renal vein, this was doubly clipped and transected. There was also noted

to be vascular structure of the upper pole, which was also doubly clipped and transected. Using the Harmonic scalpel, we were able to continue free the remainder of the adrenal glands from its attachments medially, posteriorly, cephalad, and laterally.,At this point, using the EndoCatch bag, we removed the adrenal gland through the primary port in the periumbilical region and sent the flap for analysis. Repeat laparoscopy showed no additional findings. The bowel was unremarkable, no evidence of bowel injury, no evidence of any bleeding from the operative site.,The operative site was irrigated copiously with saline and reinspected and again there was no evidence of bleeding. The abdominal cavity was desufflated and was reinspected. There was no evidence of bleeding.,At this point, the camera was switched to one of the subcostal ports and the primary port in the periumbilical region was closed under direct vision using #0 Vicryl suture. At this point, each of the other ports were removed and then with palpation of each of these ports, this indicated that the non-cutting ports did close and there was no evidence of fascial defects.,At this point, the procedure was terminated. The abdominal cavity was desufflated as stated. The patient was sent to Recovery in stable condition. Postoperative orders were written. The procedure was discussed with the patient's family at length.