PREOPERATIVE DIAGNOSIS: , Colovesical fistula.,POSTOPERATIVE DIAGNOSES:,1. Colovesical fistula.,2. Intraperitoneal abscess.,PROCEDURE PERFORMED:,1. Exploratory laparotomy.,2. Low anterior colon resection.,3. Flexible colonoscopy.,4. Transverse loop colostomy and JP placement.,ANESTHESIA: , General.,HISTORY: ,This 74-year-old female who had a recent hip fracture and the patient was in rehab when she started having some stool coming out of the urethra. The patient had retrograde cystogram, which revealed colovesical fistula. Recommendation for a surgery was made. The patient was explained the risks and benefits as well as the two sons and the daughter. They understood that the patient can even die from this procedure. All the three procedures were explained, without a colostomy, with Hartmann's colostomy, and with a transverse loop colostomy, and out of the three procedures, the patient's requested to have the loop colostomy and stated that the Hartmann's colostomy leaving the anastomosis with the risk of leaking.,PROCEDURE DETAILS: , The patient was taken to the operating room, prepped and draped in the sterile fashion and was given general anesthetic. An incision was performed in the midline below the umbilicus to the pubis with a #10 blade Bard Parker. Electrocautery was used for hemostasis down to the fascia. The fascia was grasped with Ochsner's and then immediately the peritoneum was entered and the incision was carried cephalad and caudad with electrocautery.,Once within the peritoneum, adhesiolysis was performed to separate the

small bowel from the attachment of the anterior abdominal wall. At this point, immediately a small bowel was retracted cephalad. The patient was taken to a slightly Trendelenburg position and the descending colon was seen. The white line of Toldt was opened all the way down to the area of inflammation. At this point, meticulous dissection was carried to separate the small bowel from the attachment to the abscess. When the small bowel was completely freed of abscess, bulk of the bladder was seen anteriorly to the uterus. The abscess was cultured and sent it back to Bacteriology Department and immediately the opening into the bladder was visualized. At this point, the entire sigmoid colon was separated posteriorly as well as laterally and it was all the way down to sigmoid down to the rectum. At this point, decision to place a moist towel and retract old intestine superiorly as well as to place first self-retaining retractor in the abdominal cavity with a bladder blade was placed. Immediately, a GIA was fired right across the descending colon and sigmoid colon junction and then with peons within the mesentery were placed all the way down to the rectosigmoid junction where a TA-55 balloon Roticulator was fired. The specimen was cut with #10 blade Bard-Parker and sent it to Pathology. Immediately copious amount of irrigation was used and the staple line in the descending colon was brought with Allis. A pursestring device was fired. The staple line was cut. The dilators were used using #25 and #29, then _____ #29 EEA was placed and the suture was tied. At this point, attention was directed down to the rectal stump where dilators #25 and #29 were passed

from the anus into the rectum and then the #29 Ethicon GIA was introduced. The spike came posteriorly through the staple line to avoid the inflammatory process anteriorly that was present in the area of the cul-de-sac as well as the uterine was present in this patient. ,Immediately, the EEA was connected with a mushroom. It was tied, fired, and a Doyen was placed above the anastomosis approximately four inches. Fluid was placed within the _____ and immediately a colonoscope was introduced from the patient's anus insufflating air. No air was seen evolving from the staple line. All fluid was removed and pictures of the staple line were taken. The scope was removed at this point. The case was passed to Dr. X for repair of the vesicle fistula. Dr. X did repair down the perforation of the bladder that was communicating with an abscess secondary to the perforated diverticulitis and the colon. After this was performed, copious amount of irrigation was used again. More lysis of adhesions were performed and decision to make a loop transverse colostomy was made to protect the anastomosis in a phase of a severe inflammatory process in the pelvis in the infected area. The incision was performed in the right upper quadrant.,This incision was performed with cutting in the cautery, down into the fascia splitting the muscle and then the Penrose was passed under transverse colon, and was grasped on pulling the transverse colon at the level of the skin. The wire was passed under the transverse colon. It was left in place. Moderate irrigation was used in the peritoneal cavity and in the right lower quadrant, a JP was placed in the pelvis

posteriorly to the abscess cavity that was down on the pelvis. At this point, immediately, yellow fluid was removed from the peritoneal cavity and the abdomen was closed with cephalad to caudad and caudad to cephalad with a loop PDS suture and then tied. Electrocautery for hemostasis and the subcutaneous tissue. Copious amount of irrigation was used. The skin was approximated with staples. At this point, immediately, the wound was covered with a moist towel and decision to mature the loop colostomy was made. The colostomy was opened longitudinally and then matured with interrupted #3-0 Vicryl suture through the skin edge. One it was completely matured, immediately the index finger was probed proximally and distally and both loops were completely opened. As previously mentioned, the Penrose was removed and the Bard was secured with a #3-0 nylon suture. The JP was secured with #3-0 nylon suture as well. At this point, dressings were applied. The patient tolerated the procedure well. The stent from the left ureter was removed and the Foley was left in place. The patient did tolerate the procedure well and will be followed up during the hospitalization.