PREOPERATIVE DIAGNOSIS: , Symptomatic cholelithiasis.,POSTOPERATIVE DIAGNOSIS: , Symptomatic cholelithiasis.,PROCEDURE: , Laparoscopic cholecystectomy and appendectomy (CPT 47563, 44970).,ANESTHESIA: , General endotracheal.,INDICATIONS: ,This is an 18-year-old girl with sickle cell anemia who has had symptomatic cholelithiasis. She requested appendectomy because of the concern of future diagnostic dilemma with pain crisis. Laparoscopic cholecystectomy and appendectomy were recommended to her. The procedure was explained in detail including the risks of bleeding, infection, biliary injury, retained common duct stones. After answering her questions, she wished to proceed and gave informed consent.,DESCRIPTION OF PROCEDURE: , The patient was taken to the operating room, placed supine on the operating table. She was positively identified and the correct surgical site and procedure reviewed. After successful administration of general endotracheal anesthesia, the skin of the abdomen was prepped with chlorhexidine solution and sterilely draped.,The infraumbilical skin was infiltrated with 0.25% bupivacaine with epinephrine and horizontal incision created. The linea alba was grasped with a hemostat and Veress needle was placed into the peritoneal cavity and used to insufflate carbon dioxide gas to a pressure of 15 mmHg. A 12-mm expandable disposable trocar was placed and through this a 30 degree laparoscope was used to inspect the peritoneal cavity. Upper abdominal anatomy was normal. Pelvic laparoscopy revealed bilaterally closed internal inguinal

rings. Additional trocars were placed under direct vision including a 5-mm reusable in the right lateral _____. There was a 12-mm expandable disposable in the right upper quadrant and a 5-mm reusable in the subxiphoid region. Using these, the gallbladder was grasped and retraced cephalad. Adhesions were taken down over the cystic duct and the duct was circumferentially dissected and clipped at the gallbladder cystic duct junction. A small ductotomy was created. Reddick cholangiogram catheter was then placed within the duct and the balloon inflated. Continuous fluoroscopy was used to instill contrast material. This showed normal common bile duct which entered the duodenum without obstruction. There was no evidence of common bile duct stones. The cholangiogram catheter was removed. The duct was doubly clipped and divided. The artery was divided and cauterized. The gallbladder was taken out of the gallbladder fossa. It was then placed in Endocatch bag and left in the abdomen. Attention was then paid to the appendix. The appendix was identified and window was made in the mesoappendix at the base. This was amputated with an Endo-GIA stapler. The mesoappendix was divided with an Endo-GIA vascular stapler. This was placed in another Endocatch bag. The abdomen was then irrigated. Hemostasis was satisfactory. Both the appendix and gallbladder were removed and sent for pathology. All trocars were removed. The 12-mm port sites were closed with 2-0 PDS figure-of-eight fascial sutures. The umbilical skin was reapproximated with interrupted 5-0 Vicryl Rapide. The

remaining skin incisions were closed with 5-0 Monocryl subcuticular suture. The skin was cleaned. Mastisol, Steri-Strips and band-aids were applied. The patient was awakened, extubated in the operating room, transferred to the recovery room in stable condition.