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 blunted 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.