HISTORY OF PRESENT ILLNESS: ,The patient is a 50-year-old African American female with past medical history significant for hypertension and endstage renal disease, on hemodialysis secondary to endstage renal disease, last hemodialysis was on June 22, 2007. The patient presents with no complaints for cadaveric renal transplant. After appropriate cross match and workup of HLA typing of both recipient and cadaveric kidneys, the patient was deemed appropriate for operative intervention and transplantation of kidney.,PREOPERATIVE DIAGNOSIS:, Endstage renal disease.,POSTOPERATIVE DIAGNOSIS: , Endstage renal disease.,PROCEDURE:, Cadaveric renal transplant to right pelvis.,ESTIMATED BLOOD LOSS: , 400 mL.,FLUIDS: ,One liter of normal saline and one liter of 5% of albumin.,ANESTHESIA: ,General endotracheal.,SPECIMEN: ,None.,DRAIN: , None.,COMPLICATIONS: , None.,The patient tolerated the procedure without any complication.,PROCEDURE IN DETAIL: ,The patient was brought to the operating room, prepped and draped in sterile fashion. After adequate anesthesia was achieved, a curvilinear incision was made in the right pelvic fossa approximately 9 cm in length extending from the 1.5 cm medial of the ASIS down to the suprapubic space. After this was taken down with a #10 blade, electrocautery was used to take down tissue down to the layer of the subcutaneous fat. Camper's and Scarpa's were dissected with electrocautery. Hemostasis was achieved throughout the tissue plains with electrocautery. The external oblique aponeurosis was

identified with musculature and was entered with electrocautery. Then hemostats were entered in and dissection continued down with electrocautery down through the external internal obliques and the transversalis fascia. Additionally, the rectus sheath was entered in a linear fashion. After these planes were entered using electrocautery, the retroperitoneum was dissected free from the transversalis fascia using blunt dissection. After the peritoneum and peritoneal structures were moved medially and superiorly by blunt dissection, the dissection continued down bluntly throughout the tissue planes removing some alveolar tissue over the right iliac artery. Upon entering through the transversalis fascia, the epigastric vessels were identified and doubly ligated and tied with #0 silk ties. After the ligation of the epigastric vessels, the peritoneum was bluntly dissected and all peritoneal structures were bluntly dissected to a superior and medial plane. This was done without any complication and without entering the peritoneum grossly. The round ligament was identified and doubly ligated at this time with #0 silk ties as well. The dissection continued down now to layer of the alveolar tissue covering the right iliac artery. This alveolar tissue was cleared using blunt dissection as well as electrocautery. After the external iliac artery was identified, it was cleared circumferentially all the way around and noted to have good flow and had good arterial texture. The right iliac vein was then identified, and this was cleared again using electrocautery and blunt dissection. After the right iliac vein was identified and cleared off all the alveolar tissue, it was

circumferentially cleared as well. An additional perforating branch was noted at the inferior pole of the right iliac vein. This was tied with a #0 silk tie and secured. Hemostasis was achieved at this time and the tie had adequate control. The dissection continued down and identified all other vital structures in this area. Careful preservation of all vital structures was carried out throughout the dissection. At this time, Satinsky clamp was placed over the right iliac vein. This was then opened using a #11 blade, approximately 1 cm in length. The heparinized saline was placed and irrigated throughout the inside of the vein, and the kidney was pulled into the abdominal field still covered in its protective socking with the superior pole marked. The renal vein was then elevated and identified in this area. A 5-0 double-ended Prolene stitch was used to secure the renal vein, both superiorly and inferiorly, and after appropriately being secured with 5-0 Prolene, these were tied down and secured. The renal vein was then anastomosed to the right iliac vein in a circumferential manner in a running fashion until secured at both superior and inferior poles. The dissection then continued down and the iliac artery was then anastomosed to the renal artery at this time using a similar method with 5-0 Prolene securing both superior and inferior poles. After such time the 5-0 Prolene was run around in a circumferential manner until secured in both superior and inferior poles once again. After this was done and the artery was secured, the Satinsky clamp was removed and a bulldog placed over. The flow was then opened on the arterial side and then opened on

the venous side to allow for proper flow. The bulldog was then placed back on the renal vein and allowed for the hyperperfusion of the kidney. The kidney pinked up nicely and had a good appearance to it and had appearance of good blood flow. At this time, all Satinsky clamps were removed and all bulldog clamps were removed. The dissection then continued down to the layer of the bladder at which time the bladder was identified. Appropriate area on the dome the bladder was identified for entry. This was entered using electrocautery and approximately 1 cm length after appropriately sizing and incising of the ureter using the Metzenbaum scissors in a linear fashion. Before this was done, #0 chromic catgut stitches were placed and secured laterally and inferiorly on the dome of the bladder to elevate the area of the bladder and then the bladder was entered using the electrocautery approximately 1 cm in length. At this time, a renal stent was placed into the ureter and secured superiorly and the stent was then placed into the bladder and secured as well. Subsequently, the superior and inferior pole stitches with 5-0 Prolene were used to secure the ureter to the bladder. This was then run mucosa-to-mucosa in a circumferential manner until secured in both superior and inferior poles once again. Good flow was noted from the ureter at the time of operation. Additional Vicryl stitches were used to overlay the musculature in a seromuscular stitch over the dome of the bladder and over the ureter itself. At this time, an Ethibond stitch was used to make an additional seromuscular closure and rolling of the bladder musculature

over the dome and over the anastomosis once again. This was inspected and noted for proper control. Irrigation of the bladder revealed that the bladder was appropriately filled and there were no flows and no defects. At this time, the anastomoses were all inspected, hemostasis was achieved and good closure of the anastomosis was noted at this time. The kidney was then placed back into its new position in the right pelvic fossa, and the area was once again inspected for hemostasis which was achieved. A 1-0 Prolene stitch was then used for mass closure of the external, internal, and transversalis fascias and musculature in a running fashion from superior to inferior. This was secured and knots were dumped. Subsequently, the area was then checked and inspected for hemostasis which was achieved with electrocautery, and the skin was closed with 4-0 running Monocryl. The patient tolerated procedure well without evidence of complication, transferred to the Dunn ICU where he was noted to be stable. Dr. A was present and scrubbed through the entire procedure.