PREOPERATIVE DIAGNOSIS: , Appendicitis.,POSTOPERATIVE DIAGNOSIS: , Appendicitis.,PROCEDURE PERFORMED: , Laparoscopic appendectomy.,ANESTHESIA: , General endotracheal.,INDICATION FOR OPERATION: , The patient is a 42-year-old female who presented with right lower quadrant pain. She was evaluated and found to have a CT evidence of appendicitis. She was subsequently consented for a laparoscopic appendectomy.,DESCRIPTION OF PROCEDURE: , After informed consent was obtained, the patient was brought to the operating room, placed supine on the table. The abdomen was prepared and draped in usual sterile fashion. After the induction of satisfactory general endotracheal anesthesia, supraumbilical incision was made. A Veress needle was inserted. Abdomen was insufflated to 15 mmHg. A 5-mm port and camera placed. The abdomen was visually explored. There were no obvious abnormalities. A 15-mm port was placed in the suprapubic position in addition of 5 mm was placed in between the 1st two. Blunt dissection was used to isolate the appendix. Appendix was separated from surrounding structures. A window was created between the appendix and the mesoappendix. GIA stapler was tossed across it and fired. Mesoappendix was then taken with 2 fires of the vascular load on the GIA stapler. Appendix was placed in an Endobag and removed from the patient. Right lower quadrant was copiously irrigated. All irrigation fluids were removed. Hemostasis was verified. The 15-mm port was removed and the port site closed with 0-Vicryl in the

Endoclose device. All other ports were irrigated, infiltrated with 0.25% Marcaine and closed with 4-0 Vicryl subcuticular sutures. Steri-Strips and sterile dressings were applied. Overall, the patient tolerated this well, was awakened and returned to recovery in good condition.