

PREOPERATIVE DIAGNOSIS:, Acute appendicitis with perforation.,POSTOPERATIVE DIAGNOSIS: ,Acute appendicitis with perforation.,ANESTHESIA:, General.,PROCEDURE: , Laparoscopic appendectomy.,INDICATIONS FOR PROCEDURE: , The patient is a 4-year-old little boy, who has been sick for several days and was seen in our Emergency Department yesterday where a diagnosis of possible constipation was made, but he was sent home with a prescription for polyethylene glycol but became more acutely ill and returned today with tachycardia, high fever and signs of peritonitis. A CT scan of his abdomen showed evidence of appendicitis with perforation. He was evaluated in the Emergency Department and placed on the appendicitis critical pathway for this acute appendicitis process. He required several boluses of fluid for tachycardia and evidence of dehydration.,I met with Carlos' parents and talked to them about the diagnosis of appendicitis and surgical risks, benefits, and alternative treatment options. All their questions have been answered and they agree with the surgical plan.,OPERATIVE FINDINGS: , The patient had acute perforated appendicitis with diffuse suppurative peritonitis including multiple intraloop abscesses and purulent debris in all quadrants of the abdomen including the perihepatic and subphrenic recesses as well.,DESCRIPTION OF PROCEDURE: , The patient came to the operating room and had an uneventful induction of general anesthesia. A Foley catheter was placed for decompression, and his abdomen was prepared and draped in a standard fashion. A

0.25% Marcaine was infiltrated in the soft tissues around his umbilicus and in the suprapubic and left lower quadrant locations chosen for trocar insertion. We conducted our surgical timeout and reiterated all of Carlos' unique and important identifying information and confirmed the diagnosis of appendicitis and planned laparoscopic appendectomy as the procedure. A 1-cm vertical infraumbilical incision was made and an open technique was used to place a 12-mm Step trocar through the umbilical fascia. CO2 was insufflated to a pressure of 15 mmHg and then two additional 5-mm working ports were placed in areas that had been previously anesthetized. There was a lot of diffuse purulent debris and adhesions between the omentum and adjacent surfaces of the bowel and the parietal peritoneum. After these were gently separated, we began to identify the appendix. In the \_\_\_\_\_ due to the large amount of small bowel dilatation and distension, I used the hook cautery with the lowest intraperitoneal \_\_\_\_\_ profile to coagulate the mesoappendix. The base of the appendix was then ligated with 2-0 PDS Endoloops, and the appendix was amputated and withdrawn through the umbilical port. I spent the next 10 minutes irrigating purulent fluid and debris from the peritoneal cavity using 2 L of sterile crystalloid solution and a suction power irrigation system. When this was complete, the CO2 was released one final time and as much of the fluid was drained from the peritoneal cavity as possible. The umbilical fascia was closed with figure-of-eight suture of 0 Monocryl and the skin incisions were closed with subcuticular 5-0

Monocryl and Steri-Strips. The patient tolerated the operation well. He was awakened and taken to the recovery room in satisfactory condition. His blood loss was less than 10 mL, and he received only crystalloid fluid during the procedure.