**NOTE 7**

**PATIENT 1002**

**DATE: 3/13/20**

**Date of Procedure: 03/13/2020**

**Age: 24 days (GA: 27 weeks, 4 days)**

**Weight: 920 grams**

**Pre-Procedure Diagnosis: Prior CDH repair, open abdomen with silo following bowel perforation**

**Post Procedure Diagnosis: Same**

**Procedure: Reopening of recent laparotomy, removal of silo and Gore-tex mesh, Alloderm mesh closure of fascia, partial skin closure.**

**Procedure Performed By: Dora Beard, MD**

**Assistant(s): Darla Wu, MD; Mary Arnold, MD**

**Anesthesia: GETA**

**IV Fluids: 22 mL crystalloid**

**Estimated Blood Loss: 1 mL**

**Input and Output: none**

**Tubes/Drains/Packing: AlloDerm Select Regenerative Tissue Matrix medium thickness (1.6mm)**

**REF: 151848, LOT: RH242249-014; EXP 2024-07-31**

**Findings: Removed prior silo and Gore-tex fascial patch. Sutured Alloderm to fascia as a bridge using interrupted 4-0 PDS mattresses circumferentially. Closed skin at lateral and medial aspects with Monocryl. Tacked skin to Alloderm with Monocryl.**

**Specimens: none**

**Complications: none apparent**

**Patient Condition: critical**

**Indication for Procedure: Patient, triplet A, is a 24 day old ex-27w4d infant male with prenatally diagnosed left CDH, large PDA s/p Tylenol closure, and RDS previously on HFJV. On postoperative day 2 from his bedside left CDH repair he underwent reoperation given concern for abdominal compartment syndrome and was found to have a bowel perforation. An ileocecectomy was performed, leaving him with an end ileostomy, long Hartmann's pouch, and an open abdomen with silo. Over the weekend his physiology has remarkably improved, his urine has returned to a normal rate, and he has been able to come off the jet onto the conventional vent. He now returns to the operating room for abdominal closure.**

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Description of Procedure: A NICU handoff was conducted at the patient's bedside with all team members and the patient's mother present. The patient had been recently paralyzed and a blood gas confirmed stability. We transported the patient down to the operating room and transferred him onto the operating room table. We ensured appropriate padding of all pressure points. The abdomen was prepped and draped in the standard sterile fashion. A timeout was conducted prior to beginning the operation.

We began by using scissors to cut the sutures holding the Gore-Tex patch to the fascia. The Gore-Tex patch and the adjoining silo were removed in 1 piece without any problems. We then slightly undermined the fascia bluntly, taking great care to avoid injury to the underlying bowel and the liver. We additionally raised a slight skin flap over the top of the fascia. We then sized to a AlloDerm mesh, 1.6 mm in thickness, to cover the entire fascial defect loosely. We placed the AlloDerm on the bowel such that the **slippery side faced up and the rough side faced down. The AlloDerm was secured to the fascia as a bridge, using interrupted 4-0 PDS mattress sutures circumferentially. We then closed the skin at the lateral and medial aspects, using 5-0 Monocryl mattress sutures, roughly 2-3 on either side. We then tacked the skin to the AlloDerm circumferentially with interrupted 5-0 Monocryl. This allowed approximately 30 to 40% coverage of the AlloDerm mesh with the patient's native skin. The remaining 60 to 70% of the outer mesh was covered with a moistened gauze.**

**We then directed our attention to the stoma, which we noticed had sealed shut. We therefore used electrocautery to reopen the tip of the stoma. The stoma was then dressed with a bag. The patient tolerated the procedure well and was transported back to the NICU in stable critical condition.**

**Dr. Beard was present and scrubbed for the entirety of the case.**