General Surgery: Procedure Note Sample

Patient Name:	Mary Jones	**MRN:**	63342714808
Date of Birth:	2/14/1981	**Admit Type:**	Inpatient
Age:	32	**Room:**	OR 1
Gender:	Female	**Procedure Date:**	6/25/2013

Surgical Staff: Matt T. Johnson, MD
Referring MD: Alex Smith, MD
Procedure: Laparoscopic Cholecystectomy

Pre-OP Diagnosis: Chronic right upper quadrant and epigastric abdominal pain
Cholelithiasis with chronic cholecystitis

Post-OP Diagnosis: Chronic right upper quadrant and epigastric abdominal pain
Cholelithiasis with chronic cholecystitis

Patient Profile: The patient is a 32 year old female. The patient has symptoms of abdominal pain. Refer to note in patient chart for documentation of history and physical. Previously obtained CT showed: stones found in the gallbladder. The patient has failed previous conservative treatment. Laparoscopy is recommended due to the patient's progressive symptoms. The alternatives, risks and benefits of surgery were discussed with the patient. The patient verbalized understanding of the risks as well as the alternatives to surgery. The patient wished to proceed with operative intervention. A signed and witnessed informed consent was placed on the chart. Prior to initiation of the procedure, a time-out was performed: patient identification and proposed procedure were verified by the surgeon, the nurse and the anesthesiologist, and the operative site was verified by the patient and the surgeon. The verification was performed in the pre-op area.

Anesthesia: General - Endotracheal

Findings: Gallbladder:
- Thickened gallbladder wall.
- Acute and chronic inflammation.
- Multiple multifaceted green gallstones were seen.

Description of Procedure:

Preoperative Medications / Therapy:
- Ampicillin Sulbactam (Unasyn) 3 gm IV given prior to incision.
- Knee high pneumatic compression stockings.

Abdominal Prep and Drape:
- The patient was placed on the standard operating table in the supine surgical position and sites of compression were well padded. An OG tube was placed orally. The patient was sterilely prepped with povodine iodine solution (Betadine) and draped in the usual fashion.

Laparoscope Insertion and Accessory Port Placement:
- A 10 mL solution of 0.5% bupivacaine with epinephrine was infiltrated into the proposed incision site. A small puncture incision was made in the skin infraumbilical area and was carried down through the subcutaneous tissue to the fascia. Bleeding was controlled with electrocautery. An incision was made in the fascia and the peritoneum and 0 Vicryl stay sutures were placed on both sides of the fascial incision. A 10 / 12 mm Hasson cannula was inserted through the opening into the peritoneal cavity and was fixed into place by the fascial stay sutures. The peritoneal cavity was then insufflated with CO2 to a pressure of 14 mmHg.
- A 0 degree, 10 mm laparoscope was inserted through the port into the peritoneal cavity. Initial exploration of the peritoneal cavity revealed no evidence of bowel injury or bleeding.
- Local anesthetic was infiltrated into the tissues at the proposed accessory port sites. Using small puncture incisions, one 10 mm port was placed subxiphoid area and two 5 mm ports were placed right subcostal midclavicular line and right subcostal anterior axillary line under laparoscopic vision.

Procedure Details:
- The liver was examined and the liver appeared smooth. The gallbladder was visualized and was found to be inflamed and thickened with filmy adhesions present. The adhesions to the gallbladder were taken down with sharp dissection. The contents of the gallbladder were aspirated using a 5 mm needle aspirating sound. The patient was then positioned in a reverse Trendelenburg and rotated to the left position. An instrument was inserted and was used to grasp the fundus of the gallbladder and elevate the gallbladder and right lobe of the

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liver superiorly. An instrument was inserted through the port and was used to grasp the infundibulum of the gallbladder and retract it anteriorly. The cystic duct-gallbladder junction was then carefully isolated with blunt dissection. The cystic duct, cystic artery and gallbladder neck were identified. The cystic duct was then milked distally toward the gallbladder to clear the duct of stones or stone fragments. The cystic duct was then occluded with two 5 mm clips proximally and one clip distally using a 5 mm clip applier and was then divided. The cystic artery was then occluded with two 5 mm clips proximally and one clip distally and was then divided. The gallbladder was then dissected free from the liver bed using L-hook electrocautery. Prior to complete detachment of the gallbladder from the liver, the area was carefully inspected and clips on the cystic duct and cystic artery were intact, no bleeding was present and no bile leakage was present. The gallbladder was placed into the specimen bag and withdrawn through the incision.

- Prior to closure, the peritoneal cavity was examined and evaluation showed complete hemostasis, no bleeding from the gallbladder bed and no evidence of bowel injury.

Pathology Specimen:

- Gallbladder were sent for routine pathology.

Port Trocar and Scope Removal:

- The instruments and accessory port trocars were then removed under laparoscopic visualization and there was no evidence of bleeding. The pneumoperitoneum was released and the laparoscope and the primary port trocar were then removed.

Port Closure Abdomen:

- The primary and accessory ports were closed. The fascia was closed with #0 Vicryl using interrupted technique. The skin was closed with 4-0 Vicryl using interrupted subcuticular technique.

Dressing:

- The port sites were dressed with a Bandaid and Steri-Strips.

Sponge / Instrument / Needle Counts:

- Final counts were correct.

Estimated Blood Loss:

- Estimated blood loss: 10 mL

Patient to Recovery Room:

- The patient tolerated the procedure well and was brought to the recovery room in stable condition. The procedure results were discussed with the patient and the patient's wife.

Complications: None.

Post-OP Plan: Per standing orders.

Procedure Code(s): --- Professional ---
47562, Laparoscopy, surgical; cholecystectomy

Diagnosis Code(s): --- Professional ---
574.10, Calculus of gallbladder with other cholecystitis, without mention of obstruction
789.01, Abdominal pain, right upper quadrant
789.06, Abdominal pain, epigastric

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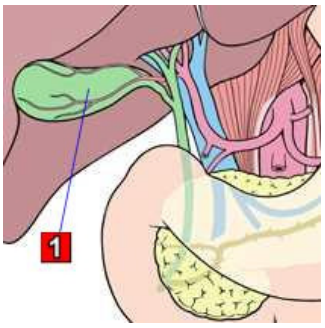
Diagram:



Gallbladder

Procedure Images:

1 Gall Bladder

Matt T. Johnson, MD
6/26/2013 1:54:43 PM
This report has been signed electronically.