PATIENT NAME: SNOW, OTTO MR.
MRN#: [redacted]
DATE OF OPERATION: 11/02/2012
DICTATING PROVIDER: Steven P. Bowers, M.D.
SURGEON: Steven P. Bowers, M.D. / [redacted] / 8
SURGICAL RESIDENT: Dustin L. Eck, M.D. / [redacted]

Location: JA_MH_04_OR 05
ASA Code: 3-III CD: 0 Post-Op Visit: Outpatient
Wound Type: 2-TYPE II - CLEAN - CONTAMINATED

PREOPERATIVE DIAGNOSES
Right inguinal hernia and symptomatic gallstones.

POSTOPERATIVE DIAGNOSES
Right inguinal hernia and symptomatic gallstones.

PROCEDURE
1. Laparoscopic right inguinal hernia repair by totally extraperitoneal technique.
2. Laparoscopic cholecystectomy with intraoperative ultrasound guidance.

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INDICATIONS
Mr. Snow is a 56-year-old male with complained of right upper quadrant pain and right lower abdominal wall pain. He had an extensive evaluation and was found to have gallstones. He also on physical exam had a blown out direct space and he had what appeared on CT scan to be a small cord lipoma. I discussed with him at length the risks and benefits of operation. He understood and signed a written informed consent.

DETAILS OF PROCEDURE
After induction of general endotracheal anesthesia, he was placed supine with his left arm tucked and padded. He was prepped and draped sterilely. A Universal Protocol was established.

An infraumbilical incision was made. The right side anterior rectus sheath was dissected free and sized longitudinally and the rectus muscle swept laterally, exposing the posterior rectus sheath. A hernia dissection balloon was placed in the pre peritoneal space and inflated under vision, and exchanged for a balloon trocar, and the pre peritoneal space was insufflated with C02 gas to a pressure of 12 mmHg, at which point 2 ports were placed in the low midline under vision. The myopectineal orifice was broadly dissected, revealing a small femoral hernia and a blown out direct space. The patient additionally had a small cord lipoma, which reduced.

A 4 x 6 UltraPro mesh was then fashioned, placed in the preperitoneal space, fixated to Cooper's ligament and to the anterior abdominal wall such that all tacks were anterior to the ileopubic tract and against the surgeon's hand.

At this point all surgical sites were inspected and found to be sterile and as pneumoperitoneum was released, we visualized that the peritoneal sac lay nicely on top of the mesh without distorting it or bunching it.

At this point, the 12 mm trocar site in the anterior rectus sheath was closed at the fascial level, with 0 Vicryl suture and a Hasan cannula was placed

through the same infraumbilical incision, through fascia and peritoneum, after they were opened sharply under vision, and other ports were placed along the costal margin.

The abdomen had been insufflated with C02 gas to a pressure of 15 mmHg and the gallbladder was grasped, held to the anterior abdominal wall in the lateral, followed by the medial peritoneal reflection of the gallbladder was taken down with the hook cautery. The critical view was established. Ultrasound guidance revealed that there was a small amount of sludge in a distal common bile duct, but there was no shadowing there. The common bile duct measured 6.25 mm. There was otherwise normal biliary and hepatic vascular anatomy. The junctions of cystic duct and common bile duct were identified and were well away from the area of dissection.

At this point, cystic duct and cystic artery were doubly clipped proximally, singly, distally and divided and the gallbladder was taken off the gallbladder fossa of the liver, without entering the parenchyma or spilling bile. The gallbladder was placed in an Endocatch bag and later retrieved through the umbilical port site.

At this point, all surgical sites were again inspected and found to be hemostatic. Other visceral and parietal surfaces in the peritoneum also appeared normal. The patient did not have any abnormality visible on the liver and at this point ports were removed under vision. Gas was desufflated. The 12 mm trocar site at the umbilicus was closed to fascial level with 0 Vicryl suture. The skin was closed with running subcuticular suture. The patient was awakened and brought to the recovery room in good condition.

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