1 Patient Information

1 PATIENT DETAILS

Name
Rachel M. Donovan

Date of Surgery
05/06/2026

DOB
11/30/1991

Surgeon
Dr. Michael T. Reyes, MD, FACS — General Surgery

Age / Sex
34 / Female

MRN
OR-2026-0882

Assistant Surgeon / PA
PA-C Jennifer Walsh — First Assist

Anesthesiologist / CRNA
Dr. Priya Nair, MD — Anesthesiology

Facility / Operating Room
Memorial Regional Medical Center — OR Suite 4

DX Pre / Post-Operative Diagnosis

2 DIAGNOSES

Pre-Operative Diagnosis
Acute appendicitis with suspected perforation — right lower quadrant pain x36 hours, fever 38.9°C, WBC 18,400, CT abdomen/pelvis: dilated appendix 10 mm with periappendiceal fat stranding and a 2.8 cm periappendiceal abscess; free air adjacent to cecum.

Post-Operative Diagnosis
Acute perforated appendicitis with periappendiceal abscess and localized peritonitis — confirmed intraoperatively. Post-operative diagnosis same as pre-operative diagnosis.

PR Procedure Performed

3 PROCEDURE

Laparoscopic appendectomy with intraoperative drainage of periappendiceal abscess and peritoneal irrigation. Three-port laparoscopic technique. The patient also underwent diagnostic laparoscopy confirming localized peritonitis limited to the right lower quadrant without evidence of generalized peritoneal contamination.

IN Indication for Procedure

4 INDICATION

Ms. Donovan presented to the Emergency Department on 05/05/2026 with a 36-hour history of progressive right lower quadrant pain (onset periumbilical, migrating to RLQ), low-grade fever (38.9°C at presentation), anorexia, nausea, and vomiting x2. WBC 18,400 with 84% neutrophils. CT abdomen/pelvis with contrast (05/05, ED radiology): 10 mm dilated appendix with mural thickening, periappendiceal fat stranding, and a 2.8 cm periappendiceal abscess adjacent to the cecal tip; tiny amount of free air adjacent to the cecum — consistent with contained perforation. Non-operative management (antibiotics + interval appendectomy) was discussed but patient's clinical presentation with peritoneal signs on examination, high WBC, and CT evidence of contained perforation with abscess made operative intervention the preferred management strategy. She and her husband reviewed and accepted surgical risks and consented to laparoscopic appendectomy.

PRE Pre-Operative Details

5 CONSENT, ANESTHESIA & POSITIONING

Consent

Anesthesia Type

Informed consent obtained by Dr. Reyes prior to surgery. Risks discussed: bleeding, infection, conversion to open, injury to adjacent structures, anesthesia risks. Patient questions answered.

General endotracheal anesthesia — RSI (rapid sequence induction) given abdominal pain and recent meal (4 hours prior to ED presentation). ETT placed without complication by Dr. Nair.

Patient Positioning
Supine, Trendelenburg position (10 degrees) and left lateral tilt (15 degrees) during cecal dissection to displace bowel away from operative field. Both arms tucked. Pressure points padded bilaterally.

Site Prep / Draping
Abdominal skin preparation with chlorhexidine gluconate 2% in 70% isopropyl alcohol — allowed to dry. Standard laparoscopic draping applied. Operative site and laterality confirmed: RIGHT lower quadrant / appendix.

Time-Out
Surgical time-out performed per institutional protocol with circulating nurse, scrub technician, anesthesiologist, and surgeon — confirmed patient identity (wristband + verbal confirmation from Dr. Nair), procedure (laparoscopic appendectomy), site (abdomen, right), allergies (NKDA), antibiotic confirmation, and equipment availability.

Antibiotic Prophylaxis
Cefoxitin 2g IV (weight-based) administered 30 minutes before incision by anesthesia — appropriate perioperative prophylaxis for colorectal/appendiceal procedure. Additional dose given intraoperatively as operative time exceeded 3 hours mark was not reached (case duration 72 minutes — no redosing required).

OF Operative Findings

6 INTRAOPERATIVE FINDINGS

Upon laparoscopic entry and establishment of pneumoperitoneum: (1) APPENDIX: The appendix was identified at the base of the cecum and was markedly dilated (estimated 12 mm external diameter), erythematous, and edematous with significant serosal injection and fibrinous exudate on the external surface. The tip of the appendix was perforated — an approximately 5 mm perforation at the distal third was identified, with surrounding fibrinopurulent material and early abscess formation in the periappendiceal tissue. (2) PERIAPPENDICEAL ABSCESS: A loculated collection of approximately 30 mL of purulent material was present in the periappendiceal region, consistent with the 2.8 cm abscess noted on pre-operative CT. The abscess was contained — no free spread to the paracolic gutter or pelvis. (3) PERITONEAL CONTAMINATION: Localized peritonitis confirmed — fibrinous exudate on the cecal serosa, right lateral peritoneum, and terminal ileum adjacent to the abscess. No generalized peritoneal contamination identified. The pelvis was inspected and was clear. (4) ADJACENT STRUCTURES: Terminal ileum: normal without involvement. Cecum: mildly edematous at the appendiceal base but otherwise intact — no signs of cecal necrosis or perforation. Right fallopian tube and ovary: visualized and normal — no involvement. Small bowel and rest of abdomen: normal. Liver: no focal lesions. (5) MESOAPPENDIX: The mesoappendix was thickened and edematous with several enlarged lymph nodes consistent with regional reactive lymphadenopathy.

OT Operative Technique

7 PROCEDURE NARRATIVE

The patient was positioned and prepared as described above. Following general anesthesia and intubation, the abdomen was entered using a standard 3-port laparoscopic approach. TROCAR PLACEMENT: A 12 mm umbilical port was placed using Hasson open technique — the abdomen was entered without difficulty and a 30-degree laparoscope was introduced. Pneumoperitoneum was established with CO2 to 15 mmHg. Intraabdominal visualization confirmed no injury from port insertion. A 5 mm port was placed in the left lower quadrant (LLQ) and a 5 mm port was placed in the suprapubic position under direct visualization. INITIAL SURVEY: Survey of the abdominal contents performed as described in operative findings. The appendix and periappendiceal abscess were identified. ABSCESS DRAINAGE: The periappendiceal abscess was carefully entered with laparoscopic suction and the purulent contents (approximately 30 mL, yellow-green, turbid) aspirated under direct vision. Care was taken not to rupture the abscess wall into the free peritoneal cavity. DISSECTION AND APPENDICEAL MOBILIZATION: The appendix was grasped at the distal tip using a laparoscopic grasper via the LLQ port. The mesoappendix was divided sequentially using LigaSure Vessel Sealing System (5 mm, Medtronic) — mesoappendix divided from distal to proximal, achieving excellent hemostasis throughout the dissection. The appendiceal base was clearly delineated at the cecal junction. The appendiceal artery was identified within the mesoappendix and confirmed divided with LigaSure without bleeding. APPENDICEAL LIGATION AND DIVISION: The appendiceal base was skeletonized for approximately 1 cm proximal to the perforation site. An Endo-GIA 45 mm blue load linear cutting stapler (Medtronic) was placed across the appendiceal base under direct vision — the stapler was fired once, dividing the appendix and creating a secure staple line at the base with no apparent staple line defect. The appendix was detached and removed in a specimen retrieval bag through the 12 mm umbilical port without contaminating the abdominal wall. PERITONEAL IRRIGATION: Warm 0.9% NaCl — 3 liters of normal saline irrigated into the right lower quadrant and pelvis under direct vision with suction and irrigation device. Irrigation continued until return was clear. No bile or succus was identified in the effluent. HEMOSTASIS: Inspected all dissection sites and trocar entry points — no active bleeding identified. Hemostasis confirmed. CLOSURE: Pneumoperitoneum released. The 12 mm umbilical fascial defect was closed with 0-Vicryl suture using Carter-Thomason closure device under direct vision. 5 mm port sites fascial closure not required per surgical protocol. All port sites irrigated at skin level. Skin closure: all three port sites closed with 4-0 Monocryl subcuticular suture. Dermabond adhesive applied over all incisions. Sterile dressings applied.

SP Specimens / Implants / Devices

8 SPECIMENS & MATERIALS

Specimens

Implants / Grafts / Devices

Appendix — complete, with periappendiceal tissue and abscess contents. Submitted in formalin to Surgical Pathology for permanent section histologic examination. Label: 'Appendix with periappendiceal tissue — R. Donovan, MRN OR-2026-0882.' Intraoperative Gram stain and aerobic/anaerobic cultures of the purulent abscess contents submitted to Microbiology.

No implants placed. LigaSure Vessel Sealing System (single-use). Endo-GIA 45 mm blue load (one cartridge fired). Specimen retrieval bag. Carter-Thomason closure device. No mesh or prosthetic material used.

Estimated Blood Loss
<20 mL — minimal blood loss throughout procedure

Fluids / Blood Products
Intraoperative: 1,000 mL Lactated Ringer's IV (anesthesia administered). No blood products.

Urine Output
220 mL (Foley catheter output during case — Foley placed by anesthesia)

Complications
No intraoperative complications encountered. No conversion to open procedure. No injury to adjacent structures — cecum, terminal ileum, right ovary, bladder all intact.

CO Counts / Disposition

9 CLOSURE & DISPOSITION

Counts
Sponge count: CORRECT x2 (before closure and at case end). Needle count: CORRECT x2. Instrument count: CORRECT x2. Circulating RN confirmed correct counts verbally.

Count Status
All counts correct — surgical team and circulating nurse in agreement.

Patient Condition at End
Patient tolerated procedure well. Stable throughout. Extubated in OR without difficulty. Transferred to PACU in stable condition.

Disposition
Post-Anesthesia Care Unit (PACU) — from PACU to general surgery inpatient unit (Room 208) when stable.

PP Post-Operative Plan

10 POST-OP MANAGEMENT

1. ANTIBIOTICS: Continue ciprofloxacin 400 mg IV Q12h + metronidazole 500 mg IV Q8h (started in ED pre-op) — plan to transition to oral cipro + flagyl when tolerating oral intake; total planned antibiotic duration 4 days (complete 05/10/2026). 2. PAIN CONTROL: Ketorolac 15 mg IV Q6h x48h (NSAIDs for post-op pain). Acetaminophen 650 mg IV Q6h ATC x48h. Oxycodone 5 mg PO Q4h PRN for breakthrough pain >6/10. Avoid excessive opioids given perforated appendicitis recovery. 3. DIET: Clear liquid diet beginning 2 hours post-op when alert and tolerating; advance to regular diet as tolerated. No dietary restrictions. 4. ACTIVITY: Ambulate tonight (POD 0) in PACU/unit with nursing assist as tolerated; no lifting >10 lbs x2 weeks. 5. WOUND CARE: Incision sites covered with Dermabond — no dressing changes required. Keep dry x48h, then can shower. No submersion x2 weeks. 6. LABS: CBC with differential AM of POD 1 (05/07) — monitor WBC trend. Pathology results expected in 2–3 business days. 7. FOLEY: Remove tonight per nursing post-op protocol. 8. DVT PROPHYLAXIS: Compression stockings. Ambulation. No pharmacologic DVT ppx ordered (short procedure, young patient, early mobilization). 9. DISCHARGE: Target POD 1 or POD 2 if tolerating oral diet, pain controlled, afebrile, and WBC trending down. 10. FOLLOW-UP: General surgery clinic in 10–14 days (05/16 or 05/20/2026). Pathology to be reviewed at follow-up.

TIME DOCUMENTATION & BILLING

Total Time
72 minutes (case duration)

E/M / Billing Code
44970 — Laparoscopic appendectomy; 44901 — Intraoperative drainage of periappendiceal abscess

Counseling / Coordination Time
N/A

Basis for Billing
Procedure-based

Primary ICD-10 Code
K37 — Unspecified appendicitis

Secondary ICD-10 Code(s)
K35.20 — Acute appendicitis with peritonitis, without abscess — UPDATE to K35.21 if pathology confirms; K65.0 — Generalized peritonitis (localized in this case)

SURGEON	CREDENTIALS	DATE	TIME
Michael T. Reyes, MD, FACS	MD, FACS — General Surgery | Board Certified (ABS)	05/06/2026	11:48 AM (procedure end)

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