
Documentation Dissection

PREOPERATIVE DIAGNOSIS: Recurrent complicated sigmoid diverticulitis.

POSTOPERATIVE DIAGNOSIS: Recurrent complicated sigmoid diverticulitis.

OPERATION PERFORMED: Laparoscopic-assisted sigmoid colectomy.

ANESTHESIA: General anesthesia with endotracheal intubation.

INDICATIONS: _____ is a ____-year-old woman who presents with recurrent and now complicated sigmoid diverticulitis. She was advised of her treatment options and elected to proceed with laparoscopic sigmoid colectomy. The nature of her problem and proposed treatment, rationale, risks, and alternatives were discussed with her and she agreed to proceed.

INTRAOPERATIVE FINDINGS:

1. Evidence of the extensive diverticulosis involving the sigmoid colon with evidence of previous acute inflammatory processes with scarring and induration of the sigmoid colon.
2. No other evidence of intra-abdominal pathology.

PROCEDURE: The patient is brought to the operating suite where she was placed under general anesthesia with endotracheal intubation. Her abdomen was then prepped and draped in usual sterile fashion. The rectum was instilled with Betadine as well.

Access to the abdomen was made through a 5 mm incision in the right upper quadrant. The Veress needle was inserted through this incision and verified to be in intraperitoneal position. The abdomen was insufflated to 15 cm of water with CO₂ and a 5 mm trocar was placed. Video peritonoscopy ensued.

There was no evidence of iatrogenic injury upon gaining access to the abdomen. A 12 mm trocar was then placed in the right lower quadrant. A 5 mm trocar in the left upper quadrant and a 5 mm trocar in the left mid abdomen. We then thoroughly explored the abdomen. We easily identified the sigmoid colon. There was no associated structures adherent to the sigmoid colon other than some post inflammatory adhesions of the sigmoid colon to the lateral abdominal lateral pelvic sidewall.

The patient was positioned in steep Trendelenburg. This allowed the hollow viscus to fall out of the pelvis. We then began the procedure by identifying the junction of the rectosigmoid. At this point the mesentery was marked as this would be the point that would be our distal point of resection. We then went ahead and took down the lateral peritoneal attachments of the sigmoid colon all way up to the level of the splenic flexure. The colon was medialized.

We could easily identify the left ureter as this patient was quite thin. It was identified through the peritoneum and preserved without injury during the entire course of this procedure. We then using the Harmonic scalpel we took down the mesentery of the sigmoid colon. This was done with a Harmonic scalpel to the point where we reached the descending branch of the inferior mesenteric artery that was taken with a vascular load of the stapler.

Having then found pliable soft bowel proximal to the sigmoid colon and roughly at the level of the junction of the descending colon and sigmoid colon, we at that point decided that would be the point of proximal division of the bowel. We then enlarged the left lower quadrant 5 mm trocar to be about a 3 cm incision with a muscle-splitting technique. The bowel was delivered out of this incision. We found a nice soft plane on the bowel at which point a pursestring device was placed on the bowel, and the bowel amputated just distal to this pursestring device.

We then went ahead and placed a 29 mm EEA anvil into this and secured the pursestring. Unfortunately, we found a small diverticulum at our staple line. For this reason, we went ahead and went up another couple of centimeters and once again placed a pursestring on the bowel and replaced the 29 mm EEA anvil into the distal bowel. The pursestring was secured. There was no diverticulum anywhere near the anvil. We then went ahead and inspected the abdominal cavity. We then went ahead and placed the descending colon back into the abdominal cavity. The fascia from the left lower quadrant incision was closed with a 1-0 Vicryl suture in a running fashion. A sterile gauze was placed in the wound. We then reinsufflated the abdomen. At this point we noticed that there was a small burn from the 5 mm laparoscopic on the abdominal wall juxtaposed to her left lower quadrant incision.

To be sure that this did not correspond to a thermal injury to any of the hollow viscus, we then reopened the left lower quadrant incision and eviscerated the transverse colon that could have been in the operative field. We then eviscerated the entire small bowel and ran the entire small bowel through this incision and found no evidence of thermal injury. The viscera was then replaced. This incision was reclosed. The abdomen was reinsufflated. Hemostasis was verified.

We then went below and then placed the stapling device through the anus up into the rectum. We then passed the spike and connected the anvil to the spike. The anastomosis was then achieved. We had two intact doughnuts upon inspection. We filled the pelvis with saline and over distended the rectum and distal descending colon and our anastomosis with gas with the catheter and found no evidence of leakage.

We reinforced the staple line with a couple of 3-0 Vicryl sutures at key points. We inspected for tension and there was actually none. There was a nice lie with no tension whatsoever. The anastomosis was freely mobile. Likewise the blood supply was excellent. There is no evidence of iatrogenic injury in the abdomen. Hemostasis was excellent. The inlet device with 1-0 Vicryl suture was used to close right lower quadrant 10/12 mm trocar site. This took two stitches.

The three remaining trocars were removed under direct visualization and found to be hemostatic as was her left lower quadrant colon extraction site. Monocryl 4-0 subcuticular stitches were used to close the skin. Sterile dressings were applied and the patient was extubated and brought to the Recovery Room.

COMPLICATIONS: None.

SPECIMENS: Sigmoid colon to pathology.

SPONGE AND NEEDLE COUNT: Correct times 2.

ESTIMATED BLOOD LOSS: 100 cc.

What are the CPT® and ICD-10-CM codes reported?
