

PROCEDURE REPORT

Name [REDACTED] DOB [REDACTED]
Care ACUT Ward 10A
Admit [REDACTED] Discharge [REDACTED]
Chart [REDACTED] PHN [REDACTED]

Date of Procedure: September 18, 2009

Performed by: Dr. C. Brown

Assistant: Dr. S. Lord, Dr. D. Davis, Dr. M. Yuen

Intraoperative Consult: Dr. P.T. Phang

This draft report is provided to support continuity of care. Blanks exist due to inaudible dictation. Please contact the physician for further information if needed.

PREOPERATIVE DIAGNOSIS:

T3 N1 rectal cancer treated with long course preoperative radiation.

POSTOPERATIVE DIAGNOSIS:

Same.

OPERATION PERFORMED:

Open low anterior resection with diverting loop ileostomy.

CLINICAL PREAMBLE:

[REDACTED] is a 55-year-old male who presented with rectal bleeding. He was found to have a fairly long tumour extending from 7.5-11 cm from the anal verge. An endorectal ultrasound was performed and this identified a T3 N1 lesion, and as such he was referred to the BC Cancer Agency for consideration of neoadjuvant therapy. He did receive long course radiation and presents today for surgical management of his rectal tumour.

PROCEDURE:

After obtaining informed consent, the patient was brought to the Operating Room. At this point, an epidural was inserted, and then a general anesthetic was administered. An endotracheal tube was placed, as was a Foley catheter. Sequential compression devices were placed upon the legs, and the patient was put in the modified lithotomy position. Preoperative antibiotics, Ancef, and subcutaneous heparin were also administered. The patient was then prepped and draped in the usual sterile fashion. A lower midline incision was made from just below the umbilicus to just above the pubis. This was deepened through the subcutaneous tissues and hemostasis was achieved with cautery. The midline was identified in the fascia and incised, and the peritoneal cavity entered. The abdomen was explored, and no liver, serosal, or peritoneal implants were identified. The small bowel was inspected, and after placing the Omni retractor, was packed into the upper abdomen and secured with a _____ retractor. We then turned our

attention
to mobilizing the colon.

Using cautery, the sigmoid was freed from its lateral peritoneal attachments along the white line of Toldt. We carried this mobilization medially, taking care to preserve the ureter. We then turned our attention to the inferior mesenteric artery. This was identified by elevating the sigmoid colon, and dissecting medially, just inferior to the superior rectal vessels and superior to the hypogastric nerve. Once the pedicle of the IMA was isolated, we identified the left ureter and preserved it. The IMA was then clamped, cut, and tied with 0 silk ties. We then chose our proximal point of incision that corresponded with our LigaSure of the inferior mesenteric artery. The colon was divided using a single firing of the 75 mm GIA stapler. The intervening mesentery was then divided by serial clamping, cutting, and tying with 0 silk ties. We then packed the sigmoid colon away and turned our attention to dissecting out the rectum.

We then entered the plane posterior to the mesorectum and anterior to the presacral fascia, and carried our dissection posteriorly. We continued our dissection circumferentially around the rectum down to the pelvic floor. We carried this dissection down to the levator muscles, and because we were aware that the tumour was quite low, performed a digital rectal examination whilst manipulating the rectum within the abdomen. We confirmed that we did indeed have what felt to be a 1-2 cm margin with which to continue our elected procedure of a low anterior resection rather than an abdominal perineal resection. The distal rectum was then transected using a single firing of the 45 mm Contour stapler. The specimen was then handed off to the pathologist, who confirmed a clear, but very close margin.

At this point, Dr. Terry Phang was contacted for an intraoperative consultation. Upon examining the specimen, and evaluating the extent of the dissection and knowledge of the patient's desire to be put back into continuity, he agreed that it would be appropriate to continue with low anterior resection, primary anastomosis, and diverting loop ileostomy. At this point, we continued with our anastomosis.

The proximal sigmoid colon was removed from where it was packed up in the abdomen, and the distal staple line was removed with cautery. The anvil of the 29 mm EEA stapler was inserted, with the spike passing through the antimesenteric wall of the colon approximately 4 cm from the opened end. This was performed in order to allow a small pouch after creating our side-to-end anastomosis. The anvil was secured with a pursestring 3-0 Prolene suture. The opened end of the sigmoid was closed with a single firing of the TX-60 stapler. The suture line was oversewn with a 3-0 Vicryl suture.

The handle of the 29 EEA stapler was then placed through the anus and the pin was advanced. The pin was passed through the middle of the distal staple line, and was then coupled with the anvil. The stapler was closed and fired, and was easily withdrawn from the anus. Both donuts were examined, and found to be intact. Because of the proximity of the tumour to the resection margin identified when the pathologist opened the specimen in the Operating Room, we elected to send the distal donut for pathologic evaluation. Rigid sigmoidoscopy was not performed, as we planned to perform a loop ileostomy.

A drain was placed in the pelvis through a separate stab incision in the left lower quadrant. This was secured to the skin with 3-0 nylon sutures. Perfect hemostasis was obtained, and we returned our attention to performing a diverting loop ileostomy. A suitable location on the patient's right abdominal wall was chosen, just inferior to where he had been marked by the stoma therapist. A disk of skin was excised, and dissection was carried down to the level of the fascia bluntly. The fascia was incised a cruciate fashion and the muscle fibres were

separated. The defect was then gently dilated to allowed the passage of two fingers. We then chose a suitable loop of terminal ileum that would pass through the ileostomy site. This was gently passed through the defect in the abdominal wall, taking care to maintain appropriate orientation. It was secured with a rod. We then closed the fascia using running looped 0 PDS sutures. The patient's skin was then closed using skin staples. The loop ileostomy was matured with interrupted 3-0 Vicryl sutures. The patient's skin was found to be dry and the wound was dressed with Mepore dressing. The stoma appliance was applied to the loop ileostomy. At the end

of the procedure, the sponge, needle, and instrument counts were all correct. The patient had tolerated the procedure well with less than 300 mL of blood loss. He was taken to Recovery in good condition.

SUMMARY:

1. Procedure: Total mesorectal excision with total anal anastomosis and diverting loop ileostomy.
2. Technique: Open.
3. Diverting ileostomy: Yes.
4. Height of tumour: From anal verge on sigmoidoscope was 7.5 cm preoperatively.
5. Height of anastomosis: From anal verge was suspected to be 3-4 cm, this was not examined using sigmoidoscopy.
6. Anastomosis: Stapled.
7. Reconstruction: Side-to-end anastomosis.
8. Colonic flexure mobilization: No.
9. Air leak test: No.
10. Multi-visceral reduction: No.
11. Intra-abdominal adhesions: None.
12. Preoperative radiation: Long course.
- 13 Preoperative staging: ERUS and CT abdomen and pelvis and chest x-ray.
14. Preoperative stage: T3 N1 MX.
15. TME Specimen: Grade 3.
16. Residual cancer: None.
17. Blood transfusion: No.
18. Unplanned events: None.
19. Operative urgency: Elective.

Sarah Lord, MD, RES for
Carl Brown, MD, FRCSC
DEPARTMENT OF SURGERY

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D: 18/09/2009 T: 01/10/2009

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