DATE: @TD@

PREOPERATIVE DIAGNOSIS: ***, Choledocholithiasis

POSTOPERATIVE DIAGNOSIS: SAME***

PROCEDURE PERFORMED:
1. Laparoscopic Cholecystectomy with common bile duct exploration under fluoroscopic guidance (CPT 47564)
2. Placement of Wire Biliary access thru biliary tree and into the small bowel (CPT 47541)
3. Balloon dilation of the biliary duct/ampulla with fluoroscopic guidance (CPT 47542)
4. Forward flushing to remove stones from bile duct (CPT 47544)

ATTENDING SURGEON: ***

RESIDENT: @MECRED@
***

BLOOD LOSS: {misc; ebl:31738}

ANESTHESIA: General endotracheal anesthesia.

COMPLICATIONS: None.

CONDITION: Stable.

DRAINS: None.

SPECIMENS: Gallbladder

DISPOSITION: To recovery room

OPERATIVE FINDINGS: The gallbladder {WAS /WAS NOT (DEFAULT):28182} inflamed. On IOC, there was obstructing filling defect with no flow into the duodenum. We proceeded with balloon sphincteroplasty of the Spincter of Oddi and then had contrast passage into the duodenum. The filling defect was *** cleared.

INDICATIONS FOR PROCEDURE: @NAME@ is a @AGE@ @SEX@ who is currently admitted to WFUBMC secondary to a diagnosis of ***. Due to this, laparoscopic cholecystectomy with IOC and possible laparoscopic common bile duct is indicated.

PROCEDURE IN DETAIL: Informed consent was obtained from the patient prior to proceeding to the operating room. The patient was then identified in the pre-anesthesia area, then taken to the operating room, placed in the supine position on the operating table, and induced under general endotracheal anesthesia. The patient was correctly positioned, padded at all pressure points and had antiembolic SCDs in place in the lower extremities. The anterior abdomen was then prepared and draped in a sterile fashion. A pre-operative timeout was then taken identifying the patient and the procedure to be performed. Preoperative antibiotics were administered at this time.

A 2cm infraumbilical curvilinear incision was made just below the umbilicus. Dissection was carried through the skin and subcutaneous tissues until the underlying fascia was visualized. The fascia was grasped and elevated. The fascia was incised sharply and the underlying preperitoneal space was entered. The peritoneal cavity was then entered. The blunt-tipped Hasson introducer cannula was placed into the abdominal cavity under direct vision and the abdomen was insufflated using carbon dioxide gas to a pressure of 15 mmHg. The epigastric and right subcostal trocars were placed under direct vision with an 11mm port placed in the epigastric region and two 5mm ports were placed in the right upper quadrant. The right upper quadrant was well visualized. The gallbladder {WAS /WAS NOT (DEFAULT):28182} noted to be inflamed. The fundus of the gallbladder was grasped and retracted anteriorly and superiorly, and the gallbladder was dissected out using a combination of the hook cautery and blunt dissection with the suction irrigator and maryland graspers. Further dissection allowed identification of the infundibulum and cystic duct junction where the cystic duct was identified and dissected out further using a

maryland grasper. At that point a critical view was obtained showing a single cystic duct and single cystic artery entering the gallbladder.

We then proceeded with our IOC. We first placed a clip superiorly on the cystic duct and made a ductotomy. Next, we established access in the abdominal cavity through the abdominal wall with a 12-gauge angiocatheter. We then placed a 6 French ureteral stent with a 0.035" Glidewire through the angiocatheter. This was placed into the ductotomy that had been previously made. We secured the ureteral stent in place with a clip. The distal end of the stent came to rest in the cystic duct. We then shot a cholangiogram and saw filling defects and an absence of contrast flow into the duodenum. We administered glucagon and then attempted power flushing with saline. This did not produce complete resolution of the filling defects.

Therefore, we advanced the Glidewire into the duodenum, removed the cystic duct clip that was securing the stent, and backed the stent out. Over the Glidewire we advanced a 5 French percutaneous transluminal angioplasty balloon. This balloon size was 6*** mm x 40 mm. We advanced it into the duodenum and inflated it with a mixture of saline and contrast so that it was radiopaque. We then gently pulled back to reveal the location of the ampulla. Once the ampulla was identified, we partially deflated the balloon and pulled the balloon back so that it straddled the ampulla. Next, we inflated the balloon to 10-12 atm of pressure to achieve the predetermined profile width. We did identify a waist in the balloon as the ampulla was dilated open.

We left the balloon inflated for 3 minutes. Next, we partially deflated and pulled the balloon back into the cystic duct. We re inflated the balloon partially and then removed the guidewire. Through the guidewire lumen, we power flushed and performed a completion cholangiogram, seeing resolution of the filling defects and passage of contrast freely into the duodenum. Satisfied with this, we removed the balloon from the duct.

The cystic duct was clipped x2 under the ductotomy and then divided. The cystic artery was dissected out in like fashion, clipped x3, and then divided. The gallbladder was then taken off the liver bed in a retrograde fashion using the hook-tip Bovie cautery with good hemostasis. No active bleeding or oozing was seen from the liver bed. All clips were noted to be secured and intact and in place. The gallbladder was retrieved via an endocatch specimen pouch through the epigastric port. The gallbladder was submitted to pathology. The abdominal cavity was then again inspected and all areas remained clean and dry and the trocars were removed under direct visualization. The insufflation was allowed to escape. The umbilical fascia and epigastric fascia were both closed using a figure of eight #0 Vicryl suture. Finally, the skin was closed in a subcuticular fashion with interrupted 4-0 monocryl. Sterile dressings were applied.

The patient was then awoken from anesthesia and taken to the PACU in stable condition.

Of Note, Dr. *** was present and directly supervising throughout the critical portions of this procedure.

The patient tolerated the procedure well.

Electronically signed by: @MEMDNR@ @TDNR@ @NOWNR@