Patient Name:	Karen Watson	Date of Birth:	22/03/1970
MRN:	0407123	Procedure date:	22/05/2018

Procedure:	Laparoscopic cholecyctectomy with intraoperative cholangiogram.
Pre-op diagnosis:	Cholecystitis with choledocholithiasis
Surgeon:	Dr Mark Crozier
Assistant:	Dr Benjamin Johnstone (Surgical registrar)

Operation details:

An infra umbilical midline incision was made and open technique was used to enter the peritoneal cavity with a Hassan needle and used to establish our pneumoperitoneum. The laparoscope was inserted into the abdomen under direct vision.

A 10 mm epigastric port and two 5 mm ports along the right costal margin were inserted under direct visualisation. The peritoneal cavity was inspected and no signs of peritonitis or ruptures were identified. Omental attachments to the gallbladder were separated and was retracted using an atraumatic grasper.

The infundibulum was identified and Calot's triangle was exposed. Gallbladder infundibulum was incised with electrocautery anteriorly. Then the posterior peritoneum was dissected. The triangle was dissected to expose: the cystic duct and cystic artery.

The cystic artery was doubly clipped and divided and the cystic duct was doubly clipped and divided.

Cholangiogram: A clip was placed on the cystic duct close to the neck of the gallbladder. A nick was made in the cystic duct and a cholangiogram catheter threaded. A cholangiogram was obtained and showed good flow of bile into the duodenum, an intact biliary tree, with a filling defect noted. Successful operative bile duct clearance was achieved.

The electrocautery was then used to separate the peritoneal attachments between the gallbladder and its bed in the liver. The gallbladder fossa and cystic artery were inspected to ensure no bleeding. Hemostasis was achieved with electrocautery. There was no leakage of bile from the cystic duct stump.

The gallbladder was retrieved using an endoscopic retrieval bag through the epigastric port. The specimen was sent to pathology.

The epigastric ports were re-approximated using the 1-0 or 0' (vicryl) sutures in a figure-of-eight. All incisions were closed using 4-0 (vicryl) sutures in a (continuous) sub-cuticular.

There were no intraoperative complications. All instrument and sponge counts were correct. A surgical de-briefing was performed. The patient was extubated and transferred to the PACU in stable condition.

Dr Mark Crozier
Armidale Hospital General Surgeon