

Operative Notes

Operative Report signed by Maxwell V Meng, MD at 4/1/2014 12:06 PM

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OPERATIVE REPORT

DATE OF OPERATION: 03/24/2014

PREOPERATIVE DIAGNOSES:

1. Left renal mass.
2. Recurrent deep vein thromboses.

POSTOPERATIVE DIAGNOSES:

1. Left renal mass.
2. Recurrent deep vein thromboses.

OPERATION: Laparoscopic left radical nephrectomy, adrenal sparing.**ANESTHESIA:** General.**CLINICAL INDICATIONS:** This is a 59-year-old man who had an incidental finding of a left renal mass on hypercoagulable workup for recurrent DVTs. The mass was approximately 4 cm, confined to the kidney on imaging. Options were discussed. The patient opted for laparoscopic left nephrectomy. He had an IVC filter placed the week prior to surgery and has been on a Lovenox bridge.**FINDINGS:** Left kidney removed, appeared intact.

PROCEDURE: After informed consent was consent, the patient was taken to the operating room and placed supine on the operating room table, and induced under general anesthesia by our anesthesia colleagues. He was given Ancef perioperative prophylactic antibiotic. He was then placed in the right lateral decubitus position with all pressure points well padded, confirmed by the entire operating room staff. The bed was flexed, and he was secured to the table. A 1 cm incision was made in line with the subcostal line at Palmer point. Veress needle was used to gain access into the retroperitoneal cavity. A saline drop test was good, and then the abdomen was insufflated to 15 mmHg, then an 11 mm step port was placed and camera was put into the port. There was no evidence of any visceral or vascular injury on entry and the peritoneal cavity looked good. There were some adhesions laterally to the left colon. The remainder of the ports were then placed in the standard fashion for a laparoscopic nephrectomy, with 4 ports. We began by taking down the adhesions with hook cautery. We then performed medial visceral rotation by taking down the white line of Toldt with our hook cautery. We found the kidney, dissected the conus, identified the ureter and the gonadal level. We were able to trace the gonadal up to its insertion at the renal vein. We then found the renal

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artery posterior to this. We used vascular staple loads to come across the renal artery first and then the vein. The hilum was rather stuck and we used several other staple loads to fire across areas that looked like they were prone to bleeding. We stayed away from the aorta, the SMA, the tail of the pancreas, and the spleen, which we identified prospectively. We then came across the cephalad aspect of the kidney and performed adrenal sparing. The posterior, lateral, and inferior attachments of the kidney were then taken with LigaSure, and then the ureter and gonadal were stapled to free the specimen completely. Hemostasis was excellent. We inspected the hilum, placed some FloSeal there, and then made an infraumbilical midline incision to extract the kidney, after placing an Alexis wound protector. We examined the kidney, it appeared intact. We then closed the extraction site with 1-0 Maxon to close the fascia in a running fashion, and then 3-0 Dexon and then 4-0 Monocryl subcuticular. We then reinsufflated the abdomen, reinspected our resection site, and again hemostasis was excellent. We then removed all our ports under direct vision and closed our ports with 4-0 Monocryl subcuticular. We infiltrated all incisions with local anesthetic. The patient was then awakened from anesthesia she was extubated and transferred to the postanesthesia care unit in good condition.

ESTIMATED BLOOD LOSS: 100 mL.

DRAINS: Foley catheter.

COMPLICATIONS: None.

SPECIMENS: Left kidney.

COUNTS: All counts were correct at the end of the case.

DISPOSITION: The patient will be admitted. We will discuss timing of restarting anticoagulation tomorrow.

I was present and participated during the entire procedure(s). I discussed the case with Dr. C. Harris and agree with the note as documented.