UNIVERSITY GENERAL HOSPITAL - DALLAS

OPERATIVE REPORT

PATIENT NAME:	MEJIA, FRANCIS
MR NUMBER:	000754
ACCOUNT NUMBER:	25482
ROOM NUMBER:	001
PHYSICIAN:	Joseph Bianco, D.O.
DATE:	6/27/2014
ADMISSION DATE:	6/25/2014
OPERATIVE DATE:	6/27/2014

SURGEON: Joseph Bianco, DO

PREOPERATIVE DIAGNOSIS: Postoperative bleed

POSTOPERATIVE DIAGNOSIS: POSTOPERATIVE BLEED

OPERATION PERFORMED:

1. Laparoscopy
2. Laparotomy
3. Ligation of cystic artery, cholecystoduodenal ligament area.

FINDINGS OF THE OPERATION: Laparoscopy: On laparoscopic exam we were able to place the laparoscope at the umbilicus, move over the transverse colon, suction the material out of the upper right quadrant and note that the patient had active bleeding. Therefore, we proceeded to laparotomy.

On laparotomy we used a Kocher's incision and the Belfour retractor with Iron Intern and upper blade. We were able to remove the clots from the cholecystoduodenal area and ligate a small vessel coming off the right hepatic. This was ligated with silk.

Once the vessel was ligated we left the pack in place and suctioned all blood and debris that we could out of the abdomen. We used a number of liters of saline to accomplish that maneuver.

Once we went back to the cholecystoduodenal area we noted not bleeding. Therefore a pack of Gelfoam and 2 Avitene's was placed in the space between the liver bad and the transverse colon.

No tissue was sent to the path lab.

PROCEDURE IN DETAIL: With the patient in the supine position and under anesthesia the abdomen was sterilely prepped and draped. The subumbilical incision was opened with scalpel. A 10 mm sheath with obturator inserted, obturator removed. Laparoscope with camera and light hook-ups was inserted. We opened the epigastric incision and the midclavicular and midaxillary incisions. We placed 5 mm ports in the midaxillary and midclavicular incisions, a 10 mm port in the epigastric incision. Using the Allis forceps we were able to lift the liver and visualize the cholecystoduodenal ligament area. This was suctioned and we noted active bleeding. Therefore, we proceeded to laparotomy.

Bianco
EXHIBIT NO. 2
7-24-15

Using the electrocautery a Kocher's incision was made between the epigastric and midclavicular ports. The incision was carried through the skin subcutaneous tissues, anterior rectus fascia, posterior rectus fascia and peritoneum. We transected the rectus muscle and the obliques doing this. Bleeding was controlled with electrocautery. Once in the abdomen the Balfour retractor was inserted in the incision with the medium blades. The third member was used to place on the rib cage area.

The Iron Intern was attached to the Balfour and using two wet lap packs the transverse colon was pushed down and out of the way. We elevated the liver bed with the Sweetheart retractor and suctioned the blood and debris in the cholecystoduodenal area. Careful inspection revealed a small bleeder coming of the right hepatic which was grasped with the Lahey forcep and ligated with a 3-0 silk. We placed a clip across it also. There was another area of bleeding and we identified it and picked it up with the Debakey forcep, and placed a medium clip across that area. The right hepatic was examined and noted to be functioning.

We irrigated the liver bed area and the cholecystoduodenal ligament. We placed two wet lap packs in that area and began suctioning all blood and debris from the abdomen. We used the irrigating tool and placed at least 4 liters of saline in the abdomen, suctioning the clots and fluid out as much as possible.

Going back to the cholecystoduodenal ligament area, the Balfour retractor was reinserted with the Iron Intern and the malleable blade along with the 3rd member for the rib cage. The retractor was opened. We then again placed the Sweetheart retractor on the liver bed. Visualization was carried out. The packs having been removed we noted no bleeding and watched for it.

Gelfoam with 2 Avitene's was gotten and placed in the space between the liver bed and the transverse colon. The packs and retractors were removed. The peritoneum was grasped with 4 Ochsner clamps and closed starting at each corner with #1 Vicryl in a continuous manner. These were tied in the middle and then the superior portion of the posterior rectus fascia was now closed with continuous #1 Vicryls. Starting at each corner #1 Vicryl was used, placed and tied and the anterior rectus fascia was closed with #1 Vicryl in a continuous manner. The subcutaneous fatty tissue was closed with a 4-layer 0-Vicryl continuous closure. The skin was closed with #1 Vicryl in a subcuticular manner, two layers were placed.

It should be noted, Jackson-Pratt had been placed through the midaxillary port and had been brought out through the skin. It was sutured to the skin using 2-0 Ethilon wrapping the Ethilon crisscross fashion back and forth on the Jackson-Pratt tubing. The Jackson-Pratt drain was activated at this point. The belly having been cleansed with saline and dried, Mastisol Steri-strips were applied to the incision. The patient having tolerated the procedure well was brought up from anesthesia and transferred to the recovery room without incident. Orders were written.

Joseph Bianco, D.O.

cc: Joseph Bianco, DO
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