PREOPERATIVE DIAGNOSIS: Chronic cholecystitis, biliary dyskinesia.

POSTOPERATIVE DIAGNOSIS: Chronic cholecystitis, biliary dyskinesia, cholesterolosis.

OPERATION PERFORMED: Laparoscopic cholecystectomy with cholangiogram.

ANESTHESIA: General.

FINDINGS AT OPERATION: This patient had a gallbladder that had some adhesions to the surface and a little bit of edema. There was good visualization of both ovaries and uterus, appendix, no other pathology could be identified.

DETAILS OF PROCEDURE: The patient was taken to the operating room and placed under adequate general anesthesia. The abdomen was prepped with Betadine and sterile drapes were arranged. An infraumbilical stab incision was made and the Veress needle was inserted into the peritoneal cavity and pneumoperitoneum was obtained. A 10-11 trocar and sleeve were introduced and the camera was passed into the peritoneal cavity. Right upper quadrant 5 mm trocars and sleeves times two were placed, and a 10-11 trocar and sleeve was placed in the epigastrium. The gallbladder was grasped by the fundus and infundibulum. Blunt dissection of the lower part of the gallbladder was undertaken until the cystic duct was isolated. A clip was placed on the duct adjacent to the gallbladder and then a small incision was made in the duct and the catheter was inserted and the x-rays via fluoroscopy were obtained using low osmolar contrast. After this the catheter was removed and the duct was doubly hemoclipped and divided. The artery was identified, proximally and distally hemoclipped and divided, anterior posterior branch was clipped and divided. The gallbladder was dissected away from the gallbladder fossa using electrocautery dissection brought up through the epigastric port without difficulty. The subhepatic and subdiaphragmatic spaces were irrigated and aspirated of excess fluid and inspected for any bleeding. Then #0 Vicryl with the Endoclose was used to place a stitch to close the fascia at the umbilicus and epigastric trocar sites. The sleeves were removed under direct visualization and the pneumoperitoneum was released. After the #0 Vicryl was tied, the subcutaneous tissue was closed using 2-0 Vicryl and the skill of all of the incisions was closed using subcuticular #4-0 Vicryl. Steri-Strips were applied and the patient was returned to the recovery room in satisfactory condition. There were no intraoperative complications. Final sponge and needle counts were all correct.