Left laparoscopic adrenalectomy anterior approach

Date of the procedure:
Preoperative diagnosis:
Postoperative diagnosis:

Procedure: Left laparoscopic adrenalectomy anterior approach

Surgeon: Denise Carneiro-Pla, M.D.
Asst.: Your name

Indication for the procedure:
Specimen:
Complications:
Findings:

Description of procedure:

Patient was brought to the operating room and timeout was performed. After placement of the endotracheal tube and NG tube, the patient was placed in a complete right lateral decubitus. The anterior and posterior axillary lines were marked before the patient was prepped and draped in a standard sterile fashion. A 10 millimeters blunt port was introduced under direct vision and the abdominal cavity was entered. Insufflation was obtained with CO2 with pressure set 13 mmHg. Another 5 millimeters port was introduced in the epigastric area under direct vision after local anesthetic was injected in the peritoneum and skin. We then started with the freeing of several adhesions of the left colic angle to the parietal wall with exposure of the inferior edge of the spleen. Another 10 millimeters port was introduced at the midaxillary line under direct vision after local anesthetic was injected in the skin and peritoneum. We then began the spleen mobilization from the left parietal wall using the Bovie hook and scissors with monopolar cautery. With a very gentle retraction of the spleen, we can completely mobilize this organ medially. The splenic flexure of the colon was reflected inferiorly in order to have a better access to the spleen and adrenal gland. The pancreatic tail as well as the splenic vessels were identified and reflected medially en bloc with identification of the avascular plane along the Gerota’s fascia below the pancreas. This dissection allowed the identification of the main adrenal vein as well as the phrenic vein.
The renal vein was identified and the procedure ligation of the main adrenal vein with double medium clips. Medial adrenal artery was identified and divided between clips. At this point the gland was dissected from caudad to cephalad until the diaphragm. At the upper edge of the gland, the superior and adrenal pedicle vessels were then identified, dissected, ligated with clips and divided. We then proceeded with dissection of the lateral and inferior borders of the adrenal gland. Further dissection was conducted between the adrenal gland and the kidney using the harmonic scalpel. The inferior pedicle was identified and ligated. A combination of Bovie hook and harmonic until the kidney was clearly identified. After these vessels were ligated, and harmonic scalpel was used to divide the attachments in the posterior portion of the adrenal gland from the muscle. Hemostasis was assured at this point and after irrigation there were no signs of major bleeding. Surgicel was placed on the adrenal bed and the gland was removed from the abdominal cavity using an Endo Catch. This 10 millimeters port was reinserted after the specimen was removed and sent to the back table. Hemostasis was once assured and we proceeded with the removal of the ports assuring there no bleeding was present. The 2 10 millimeters ports were closed using Prolene 0-0 in a separate fashion using figure-of-eight stitches. The skin was then closed with Monocryl in subcutaneous stitches. Dermabond was placed as well as Steri-Strips. The patient was then awakened sent to recovery room in stable condition. Dr. Carneiro-Pla was present throughout the entire procedure.