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* Preliminary Report *

DATE OF PROCEDURE: 03/26/2015.

PRE-OPERATIVE DIAGNOSIS: Ureteropelvic junction obstruction.

POST-OPERATIVE DIAGNOSIS: Right ureteropelvic junction obstruction with crossing vessels, pigmented lesion on right hip, diaphragmatic hernia.

PROCEDURES PERFORMED:

SURGEON: Cilento, Bartley G Jr, MD, MPH, present and scrubbed for the procedure in its entirety.

ASSISTANTS: Kurtz, Michael, MD.

ANESTHESIA: General endotracheal anesthesia, local anesthetic.

DRAINS: 1. # 12 French chest tube in right chest. 2. # 4.8 French x 16 centimeter right ureteral stent.
3. # 10 French Foley catheter to gravity.

SPECIMENS: 1. Urine culture. 2. Ureteropelvic junction. 3. Right hip pigmented lesion.

COMPLICATIONS: None.

INDICATIONS FOR PROCEDURE: Aiden is a 9-year-old young man with heterotaxy. He is status post Ladd's procedure. He is also status post complex cardiac procedures. He was found to have a T-one-half of greater than
100 minutes and 40% function of the right kidney. Arrangements were, therefore, made for repair. Risks and benefits were discussed, including bleeding, infection, damage to adjacent structures, need for additional procedures, pain, scar formation, recurrent stricture, urine leak.

DETAILS OF PROCEDURE AND FINDINGS: Aiden was identified in the preoperative holding area. Informed consent was obtained from his parents.

He was wheeled to the main operating room of Boston Children's Hospital and underwent a smooth induction of general endotracheal anesthesia in the dorsal supine position. He was repositioned in the gentle dorsal lithotomy position, and all pressure points were padded. His genitals, lower abdomen, and perineum were prepped with Betadine and draped in the usual sterile fashion, and a universal World Health Organization (WHO) compliant hard stop time-out was completed by the members of the team. He received intravenous Ancef.

The procedure commenced with cystoscopy. A # 9.5 French offset cystoscope was advanced into the bladder. A urine culture was obtained. The ureteral orifices were orthotopic in position and character. A # 5 French open-ended ureteral catheter was advanced through the right ureteral orifice and a pyelogram performed. We did this because of his complex venous anatomy and the potential for a retrocaval ureter. No retrocaval ureter was identified, and a moderately high insertion of the ureter was seen into the renal pelvis. There was a tremendous dilution of contrast as the contrast entered the renal pelvis consistent with obstruction.

The cystoscope was withdrawn and this portion of the procedure completed. A # 10 French Foley catheter was placed in the urethra.

The patient was repositioned in the modified flank position with the right flank elevated. A pigmented lesion at this point was noted on the right hip, and the consent was obtained

regarding its removal at the end of the case. A second time-out was completed.

Intraperitoneal access was gained via Hasson technique through a supraumbilical incision. We carried down our incision sharply and entered the peritoneum itself sharply. We placed a step device within the peritoneal cavity, as well as a 12 mm trocar. The abdomen insufflated evenly to 15 cm H2O. There was no evidence of visceral injury, although there were small bowel-to-large bowel adhesions. We made a sharp incision and placed a robotic port in the right lower quadrant and made an incision in the epigastrium to place the robotic port here. At this point the anesthesia team noted increased pressures with ventilation. On careful inspection of the diaphragm, there was an approximately 1 cm hole. This was mature and was just above the dome of the liver.

Given these findings, Dr Jennings was consulted. He has dictated a separate operative note, but, in short, a fr12 chest tube was placed under direct vision in the right hemithorax, and the site was closed using Ethibond suture in an interrupted fashion. An adidtional stab incision was made in the right mid-abdomen to allow for an additional instrument to be used.

Attention was then turned to pyeloplasty. The robotic system was docked. Using DeBakey forceps and scissors, we dissected within Gerota's fascia anteriorly along the kidney. The pelvis was somewhat separate and quite medial in its displacement. Due to the unusual anatomy, we converted the mid-abdominal incision to a 5mm port to allow for laparoscopic assistance. We identified lower pole crossing vessels. The ureter was freed cephalad and caudad to these vessels, and no attempt was made to skeletonize these vessels themselves. The ureter was then transected at the level of the caudal-most aspect of the renal pelvis and transposed anterior to the crossing vessels. Anastomosis was undertaken with 5-0 Vicryl in interrupted fashion times five at the heel of the anastomosis and then run closed on each side. Before closure, a # 4.8 French x 16 cm stent was placed over a 0.025 wire into the bladder. The proximal coil was then placed into the renal pelvis itself, and the anastomosis was closed with 5-0 Vicryl suture. At this point, the surgical bed was completely hemostatic, and the ports were removed. Transabdominal ultrasound was used to confirm the bladder coil of the stent.

Attention was then turned to the right hip. An approximately 5 mm pigmented lesion was seen with irregular borders. This was excised in elliptical technique and closed using vertical mattress 5-0 Monocryl suture.

The port sites were closed using figure-of-eight 2-0 Vicryl suture, with the exception of the umbilical port fascia, which was closed using running 2-0 Vicryl suture. The skin was closed using subcuticular 5-0 Monocryl. A dressing of Dermabond was applied to all wounds. Sponge and needle counts were correct. This is to state that Dr Cilento was present and scrubbed for the procedure in its entirety.

Completed Action List:

* Perform by KURTZ MD, MICHAEL P on March 26, 2015 13:16 EDT
* Transcribe by on March 26, 2015 13:30 EDT
* Sign by KURTZ MD, MICHAEL P on March 26, 2015 18:32 EDTRequested on March 26, 2015 13:58 EDT
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