

**SUPPORTING TEXT EXERCISE
COLON CASE**

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Procedure Note
11/14/2007

Indications: Heme positive stool. Rectal bleeding.

Procedure: Colonoscopy

Medicines: Midazolam 3 mg IV, Meperidine 75 mg IV

Complications: None

Procedure: A History and Physical has been performed on this white female and medication allergies have been reviewed. The risks and benefits of the procedure and the sedation options and risks were discussed with the patient. All questions were answered and informed consent was obtained. Patient identification and proposed procedure were verified prior to the procedure by the physician in the procedure room at 12:45 PM.

Mental Status Examination: Alert and oriented

Airway Examination: Normal oropharyngeal airway and neck mobility

Respiratory Examination: Clear to auscultation

CV Examination: Normal

ASA Grade Assessment: P2 A patient with mild systemic disease.

After reviewing the risks and benefits, the patient was deemed in satisfactory condition to undergo the procedure. The anesthesia plan was to use moderate sedation/analgesia (conscious sedation). Immediately prior to administration of medications, the patient was re-assessed for adequacy to receive sedatives. The heart rate, respiratory rate, oxygen saturations, blood pressure, adequacy of pulmonary ventilation, and response to care were monitored throughout the procedure. The physical status of the patient was re-assessed after the procedure.

After I obtained informed consent, the scope was passed under direct vision. Throughout the procedure, the patient's blood pressure, pulse, and oxygen saturations were monitored continuously. The Olympus scope CF-Q180AL (2602978) was introduced through the anus and advanced to the cecum, identified by the appendiceal orifice. The colonoscopy was performed without difficulty. The patient tolerated the procedure well. The quality of the prep was adequate.

Findings: Cancer at 12 cm

Impression: Cancer

Recommendation: Operation, with sigmoid resection

Discharge Summary

Date of Admission: 11/16/2007

Date of Discharge: 11/22/2007

Chief Complaint: Sigmoid colon cancer

History of Present Illness: This is a 58-year-old white female who underwent a colonoscopy while she was visiting in China, and during that exam they found an abnormal growth. She had a colonoscopy for complaints of rectal bleeding. When she returned to the states, she went to see doctor. She was re-scoped on 11/14/2007, and she was found to have a large sigmoid colon carcinoma. The patient was therefore counseled to undergo sigmoid colon resection.

Hospital Course: The patient underwent surgery 11/16/2007. After adequate recovery in the PACU, she was transferred to the Med Surg unit. The patient did very well postoperatively. By postoperative day 3, she was started on a clear liquid diet. She was ambulating in the hall without difficulty. PCA pump was adequate in controlling her postoperative pain. Incision line was clean and dry. By postoperative day 4, she was passing flatus. She was progressed to a soft diet. She was ambulating in the hall without difficulty. Vital signs were stable. PCA pump was discontinued and she was switched to p.o. Percocet, which was effective in controlling her postoperative pain. On discharge day 11/22/2007, she is ambulating in the hall without difficulty. She has tolerated a regular diet without difficulty. She has adequate bowel function. Incision line is clean and dry, and she has adequate pain control with p.o. Percocet. She will be discharged home today, to be followed up in the colorectal clinic in 1 week for staple removal.

Significant Labs and X-Rays: Please see chart

Diagnostic Procedures: None

Principal Diagnoses:

1. Sigmoid colon resection
2. Sigmoid colon cancer

Other Secondary Diagnosis:

1. Hypokalemia
2. Hypomagnesemia
3. Hypertension
4. Hypocalcemia
5. Low phosphorus

Operations: On 11/16/2007, the patient underwent an exploratory lap, sigmoid resection, takedown of splenic flexure, and a colorectal anastomosis.

Description of Condition on Discharge: Chief complaint has been resolved

Discharge Disposition: The patient is being discharged home, once again, to be followed up in the colorectal clinic in 1 week for staple removal. She is being discharged home on her routine preop medications and Percocet 5/325 one to 2 q.4-6 hours p.r.n. for pain. She has been instructed on no heavy lifting, no driving. She may shower, and she has been instructed to return to clinic in 1 week.

History and Physical
11/16/2007

58-year old female patient presents today for preoperative evaluation. The patient is scheduled for sigmoid colectomy for colon cancer. Pt had colonoscopy done in China when an abnormality was found. Unfortunately all her records are in Chinese. We are in the process of getting these records interpreted. She had repeat colonoscopy done by doctor on 11/14/2007 when a colon cancer was found at 12 cm. After counseling, pt and husband agreed to undergo resection. She denies appetite problems, bladder complaints, bowel complaints, chills, fever, frequency, nausea, pain and urgency.

Admission paperwork was accomplished.

The procedure was explained to the patient, including indications, risks, and alternatives. They appear to understand and have given informed consent.

Medical History: None

Past Medical History: Hypertension

Past Surgical History: Cesarean section X 1

Medications: Hyzaar 12.5 mg PO qd

Allergies: No known allergies

Social History: Lives with family. Doesn't smoke. Uses alcohol socially. Never used drugs.

Family History: Sister at age 65 colon cancer

Review of Systems:

General: No fever, chills, fatigability or weight loss

Chest: Denies DOE, cyanosis, wheezing, cough and sputum production

Cardiovascular: Denies chest pain, PND, orthopnea or reduced exercise tolerance

PE: 130/80, 70, 20

Appearance: Well nourished, well developed, in no acute distress

Chest: Lungs clear. Normal respiratory effort.

Cardiovascular: Normal S1, S2. No rubs, murmurs or gallops. No edema.

Abdomen: Soft. No tenderness or masses. No hepatosplenomegaly.

Plan: Medical clearance per PCP, to get CAT scan today, proceed with procedure

FU: After hospitalization

Operative Report
11/16/2007

Preoperative Diagnosis: Sigmoid colon cancer

Postoperative Diagnosis: Sigmoid colon cancer

Procedure: Sigmoid colectomy

Anesthesia: General endotracheal

Estimated Blood Loss: 200 mL

Indications: This is a 58-year-old female found recently to have a mass of the sigmoid colon on colonoscopy. She presents at this time for surgical resection.

Procedure: After informed consent was obtained, the patient was taken to the operating room and placed on the operating room table in supine position. General endotracheal anesthesia was induced without complications. The patient was then positioned in lithotomy position and the abdomen and perineum were prepped and draped in a sterile fashion. A 10 blade scalpel was used to create a midline incision, and the underlying subcutaneous tissue was divided with electrocautery. The midline abdominal fascia was then divided with electrocautery and the underlying peritoneum was sharply entered. Once the entire midline had been exposed, a Bookwalter retractor was assembled. Inspection of the peritoneal contents revealed no evidence of metastatic spread of disease. The small bowel was then sequestered in the right upper quadrant using a moist towel, and mobilization was begun along the descending and sigmoid colon using electrocautery just medial to the white line of Toldt. The tumor was easily palpable and dissection was continued down to the level of the upper rectum. A site for our proximal division of the colon was selected at the proximal sigmoid level and a 75 mm linear stapler was used to divide the colon at this point. Division of the mesentery was then performed, with the IMA divided at its origin and ligated using 2-0 Vicryl ties. The remaining mesentery was divided distally until a generous margin of colon was obtained below the tumor. The colon was then divided at the rectosigmoid junction, again using a 75 mm linear stapler. The specimen was passed off the table for pathologic evaluation.

In order to create a tension-free anastomosis, further mobilization of the descending colon was continued using electrocautery. The splenic flexure was quite high and was carefully mobilized using electrocautery to divide the splenicocolic attachments. The greater omentum was separated away from the colon and splenic flexure and along the transverse colon through its avascular plane using electrocautery. Once an adequate length of descending colon had been mobilized, the proximal divided end was prepared for anastomosis using a Fansler clamp to create the pursestring, and a 29 mm stapler anvil was inserted. The pursestring was then tied down securely. Next, the 29 mm stapler was inserted via the anus and pin was deployed. The two ends were then brought together the staple anastomosis was created. Once the stapler had been removed, the anastomosis was tested by filling the pelvis with sterile saline and insufflating the rectum using a proctoscope. There was no evidence of anastomotic leak. The entire peritoneal cavity was then irrigated with sterile saline and the abdominal fascia was reapproximated using

#1 PDS suture in running fashion. Skin staples were used to reapproximate the skin edges. Sterile dressings were applied. The patient was awakened from anesthesia and taken to the recovery room postoperatively in stable condition. There were no complications. All sponge and needle counts were reported as correct at the end of the case.

Pathology Report
11/16/2007

Clinical Diagnosis/Information: Colon cancer

Specimen:

1. Sigmoid colon
2. Distal and proximal doughnuts

Final Pathologic Diagnosis:

Invasive moderately differentiated colonic adenocarcinoma, 4 cm in greatest dimension (Gross measurement). Tumor invades through muscular propria and into pericolic soft tissue. Margins (Both proximal and distal): Free of involvement by malignant neoplasm. One of sixteen lymph nodes identified positive for metastatic carcinoma (1/16). Foci of adenomatous change within the nearby overlying colonic mucosal surface.