BLACKMER,HUGH 292-02-63 M 73 SEP 16,1943

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OPERATIVE REPORT

CHANG,PETER
Signed Electronically by CHANG,PETER on SUN FEB 19,2017 8:21 AM

Name: BLACKMER, HUGH Unit No: 2920263

Service: Date: 02/16/2017

Date of Birth: 09/16/1943 Sex: M

Surgeon: Peter Chang, MD 30090

PREOPERATIVE DIAGNOSIS: Prostate cancer.

POSTOPERATIVE DIAGNOSIS: Prostate cancer.

PROCEDURE:
1. Robot-assisted laparoscopic radical prostatectomy.
2. Robot-assisted laparoscopic bilateral pelvic lymph node dissection.

ASSISTANT: Marc D. Manganiello, MD, and Jared P. Schober, MD.

ANESTHESIA: General.

SPECIMEN:
1. Prostate and seminal vesicles.
2. Anterior prostate fat.
3. Right pelvic lymph nodes.
4. Left pelvic lymph nodes.

DRAINS: 18-French Foley catheter, 19-French Blake drain.

COMPLICATIONS: None.

ESTIMATED BLOOD LOSS: 500 cc.

INTRAVENOUS FLUIDS: 1600 cc.

INDICATION FOR PROCEDURE: Mr. Blackmer is a 73-year-old man with a very large prostate and a mixture of Gleason 3 + 4 and 3 + 3 prostate cancer. He was counseled regarding his treatment options and elected to undergo radical prostatectomy.

DETAILS OF PROCEDURE:

The patient was seen in the preoperative area and history and physical and surgical consent were reviewed. He was brought to the operating room, where he was placed under satisfactory general anesthesia. Pneumoboots were also activated. He was

then placed in the low lithotomy position on a split leg bed, and his arms were tucked. He was secured to the operating room table using the TrendGuard device. We then tested the extreme Trendelenburg position, and the patient did not have any movement on the surgical bed. A surgical time-out was performed and 2 g of IV cefazolin were administered preoperatively.

The Veress needle was used to insufflate the peritoneal cavity up to 15 mmHg. We used the 12 mm Visiport to gain access to the peritoneum peri-umbilically. We used a 10 mm laparoscopic camera was used to guide placement of a left lateral 8 mm robotic port and a left medial 8 mm robotic port. We then placed a right lateral 12 mm port, a right superior 5 mm screw port, a right medial 8 mm robotic port without difficulty.

After all ports were placed, we placed the patient in moderate Trendelenburg position, and docked the Da Vinci surgical robot. Further lysis of adhesions performed until clear access to the deep pelvis could be obtained. We made an incision in the peritoneum anterior to the rectum, and exposed the vas deferens bilaterally. Starting on the right, we ligated the right vas deferens, and dissected free the right seminal vesicle anteriorly and posteriorly. The lateral vascular pedicle of the seminal vesicle was controlled using Hem-o-Lok clips. We then exposed and divided the left vas deferens, and used the bipolar electrocautery to control the left vascular pedicle to the left seminal vesicle, which was also dissected free anteriorly and posteriorly. We then used the locking grasper to lift the vas deferens and seminal vesicles superiorly and anteriorly, and made an incision into Denonvilliers' fascia approximately 1 cm posterior to the seminal vesicles.

Perirectal fat was visualized, and we performed a posterior dissection of the prostate. On the right, we found the plane between the anterior and posterior layers of denonvillers fascia, keeping the posterior layer posteriorly in a right-sided nerve-sparing approach. On the left, we visualized peri-rectal fat, keeping denonvillers fascia anteriorly, in a partial-nerve sparing approach.

We then proceeded with the bladder drop. Starting on the right, incision was made in the anterior peritoneum and plane was developed posterior to the pubic symphysis, exposing the right endopelvic fascia. We then turned our attention to the left, where we made an incision in the peritoneum lateral to the left medial umbilical ligament, and dissected down medially and inferiorly posterior to the pubic symphysis, exposing the left endopelvic fascia. We then went to the midline, and ligated the right medial umbilical ligament, the urachus, and the left medial umbilical ligament using the monopolar cautery, and released the anterior attachments of the bladder to the anterior wall, exposing the prostate.

We then spent some time clearing off the fat anterior to the prostate, sending this off as a specimen for permanent section. We incised the right endopelvic fascia and exposed the right lateral aspect of the prostate. We did the same on the left, incising the left lateral endopelvic fascia, and exposing the left lateral aspect of the prostate.

We then proceeded with division of the bladder neck anteriorly. With the ProGrasp robotic forceps, we retracted the bladder superiorly, exposing the junction between the bladder and the prostate, which was divided using the bipolar cautery. Once the anterior bladder neck was incised, we used the Foley catheter to provide further anterior and superior retraction to the prostate.

We then carefully divided the posterior urethra after retracting anteriorly on the prostate. We then incised the posterior longitudinal detrusor muscle, allowing us to join with the space created by the previous posterior dissection.

The right seminal vesicle was lifted up and retracted superiorly and medially, and we proceeded to divide the right vascular pedicle of the prostate using a series of Hem-o-Lok clips. On the right, we performed a nerve sparing approach, where we stayed preserved as much of the neuromuscular bundle as possible without incising the prostatic capsule. On the left, we performed a partial-nerve sparing approach, staying further from the prostate and keeping a layer of tissue on the prostate posteriorly in a wider resection in order to account for potential extraprostatic extension.

We then proceeded with the division of the dorsal venous complex. After a Foley catheter was inserted through the prostatic urethra, the ProGrasp forceps was used to retract the prostate superiorly. Continued retraction superiorly with the ProGrasp forceps allowed us to visualize the apex of the prostate as it became exposed through a division of the dorsal venous complex sharply. The urethra could be visualized distal to the prostate, and the prostate was rolled to the right and to the left to allow division of the remaining prostatic attachments. The bleeding dorsal venous complex was oversewn with a running 3-0 V-loc suture.

The urethra was then divided distal to the prostatic apex and the Foley catheter was re-visualized, which was pulled back slightly to allow for division of the posterior aspect urethra, freeing up the prostatic specimen.

BILATERAL PELVIC LYMPH NODE DISSECTION: We then proceeded with a pelvic lymph node dissection, starting on the right. We used the ProGrasp forceps to retract the bladder medially, and performed an obturator lymph node dissection with the borders of our dissection being the right external iliac artery anteriorly, the obturator nerve posteriorly, the pelvic sidewall inferiorly. The obturator nerve was clearly visualized, and all lymphatic attachments were controlled using Hem-o-Lok clips. Additional Hem-o-Lok clip was placed on to the right pelvic lymph node specimen to mark that it came from the right side. We then proceeded with the procedure left, retracting the bladder medially and exposing the tissue between the external iliac vein and the obturator nerve on the left. The distal border of the dissection was against the pelvic sidewall. All lymphatic and vascular attachments were controlled using Hem-o-Lok clips. We then used a 10 mm EndoCatch bag and placed all the specimens including the right pelvic lymph nodes, left pelvic lymph nodes, and the prostate seminal vesicles into the bag, and kept the bag in the peritoneal cavity.

We then set the intra-abdominal pressure to 7 mmHg, carefully inspected for any significant bleeding. All bleeding vessels were oversewn using figure-of-eight 4-0 vicryl sutures meticulously. The Foley catheter was inserted through the urethra, and a 2-0 Vicryl stitch on a UR6 needle was used to approximate the posterior urethra and the posterior bladder neck using a slip knot.

We then used an intertwined 3-0 V-Loc suture to start the vesicourethral anastomosis in a Van Velthoven technique, using the left side in a running fashion from the 7 o'clock position to the 11 o'clock position, and the right side in a running fashion from the 5 o'clock position up to the 1 o'clock position. An additional 2-0 Vicryl on a
UR6 needle in a figure-of-eight fashion was used to tighten the anterior bladder neck. The 2 V-loc stitches were then tied together anteriorly after insertion of the new Foley catheter. The Foley catheter was then irrigated with 120 mL of normal saline, and there was no evidence of leak. Ten mL of sterile water was instilled into the balloon.

The robot was then undocked, and we brought the specimen string connected to the bag out of the umbilical camera port. We then placed a 19-French Blake drain through the left lateral robotic trocar port into the deep pelvis and secured the drain using a 2-0 nylon stitch. All trocars were then removed under direct vision with no evidence of bleeding. We extended the periumbilical incision to allow for removal of the specimen bag, and closed the rectus fascia using interrupted figure-of- eight 0 PDS sutures. We closed the right lateral 12 mm port under direct vision using a 0-vicryl stitch on a UR-6 needle. All ports were irrigated, and 0.5% bupivacaine was instilled into all the incision sites. The incision sites were then closed using 4-0 Monocryl suture. Sterile dressing was applied, and the Foley catheter was secured using 2 Cath-Secures. The patient was then reversed and extubated and brought to the Post Anesthesia Care Unit in stable condition. He tolerated the procedure well and there no complications. I was present and scrubbed for the entire procedure.

Peter Chang, MD 34-AAN
I was physically present during all critical and key portions of the procedure and immediately available to furnish services during the entire procedure, in compliance with CMS regulations.

Dictated By: Peter Chang, MD

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