23 Resection of Omphalomesenteric Duct Remnant

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Indications and Benefits

- Persistent omphalomesenteric duct
- Benefits: Removal of duct

Risks and Alternatives

- Standard risks (bleeding, infection, need for additional procedures, risks of anesthesia)
- Injury to adjacent structures ({small bowel})
- Alternatives: None

Essential Steps

1. Cannulate duct (if possible)
2. Curvilinear incision circumscribing the edges of duct
3. Carry dissection along duct edges
4. Free duct from fascia
5. Eviscerate base attached to small bowel
6. Excise omphalomesenteric duct
7. Close fascia
8. Umbilicoplasty

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Template Operative Dictation (Open)

Preoperative Diagnosis Omphalomesenteric duct remnant

Postoperative Diagnosis Same as preoperative diagnosis

Findings Same as postoperative diagnosis

Procedure(s) Performed Resection of omphalomesenteric duct remnant

Anesthesia General

Specimen {Omphalomesenteric duct}

Drains {None}

Implants {None}

Estimated Blood Loss ___

Indications This is a/an ___-*day/week/month/year*-old *male/female* with an omphalomesenteric duct remnant. He/she was deemed to be a suitable candidate for resection of omphalomesenteric duct remnant.

Procedure in Detail Following satisfactory induction of anesthesia, the patient was placed

© Springer Nature Switzerland AG 2019
D. J. Papandria et al. (eds.), *Operative Dictations in Pediatric Surgery*,
https://doi.org/10.1007/978-3-030-24212-1_23

in the supine position and appropriately padded. Timeouts were performed using both pre-induction and pre-incision safety checklists with participation of all present in the operative suite. These confirmed the correct patient, procedure, operative site, and additional critical information prior to the start of the procedure. The abdomen was then prepped and draped in the usual sterile fashion.

The umbilicus was inspected and a small probe was placed in the orifice of the patent duct. A curvilinear circumferential incision was made lateral to the edges of the duct. Dissection was carried down through the subcutaneous tissue along the edge of the duct to the level of the fascia. A right angle was placed on the right edge of the fascia–duct interface, and the fascia was opened under direct vision. The same maneuver was performed on the left side of the duct. This allowed the intestinal base of the duct to be eviscerated and inspected. The base of the duct was transected longitudinally with an EndoGIA stapler, and the bowel was returned to the intra-abdominal cavity. The duct was passed off the field as specimen. The fascia was then closed in an interrupted fashion using PDS. The edges of the umbilical incision were reapproximated using Vicryl in an inverted dermal fashion to complete the umbilicoplasty. A sterile pressure dressing was placed on the umbilicus.

Upon completion of the procedure, a debriefing checklist was completed to share information critical to the postoperative care of the patient. The patient tolerated the procedure well, *was extubated in the operating room*, and was transported to the post-anesthesia care unit in stable condition thereafter.