# Open Right Hemicolectomy

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## Preference Card

- Number 10-blade scalpel with handle
- Abdominal wall retractor (surgeon preference, Bookwalter, Thompson, Balfour, large or extra-large wound protector)
- Toothed and non-toothed forceps (Adson-Brown, DeBakey, rat tooth, Bonney)
- Curved Metzenbaum and Mayo scissors
- Electrocautery, vessel sealing device
- Kocher, Allis, and Babcock clamps
- Kelly, mosquito hemostats
- Retractors (Richardson, Deaver, Army Navy)
- Needle drivers
- Linear cutting stapler
- Suction
- Sutures
  - 0 polyglactin ties
  - 2/3.0 polyglactin
  - 3.0 polydioxanone
  - 1 looped polydioxanone
  - Skin stapler or 4.0 absorbable sutures for skin closure

## Patient Positioning/Operating Room Setup

- Modified lithotomy position with legs in stirrups to provide easy access to perineal region (in case an intraoperative colonoscopy is needed); thighs are flexed (see Fig. 11.1).
- Abduct and secure arms on padded arm boards (max 90°).
- Prep and drape the abdomen.
- The perineal region does not need to be prepped, but easily accessible.
- The surgeon is positioned to the patient's right; the assistant is to the patient's left; the second assistant can stand either to the left of the first assistant or between the patient's legs (see Fig. 11.2).
- The scrub nurse is to the right of the surgeon.
- Insert Foley catheter.

## Nodal Points

### Type of Incision

- Midline skin incision (see Fig. 11.3) above and below the umbilicus, using 10-blade scalpel, extending cranially or caudally if needed

### Approach

- Obtain controlled entry into the abdomen. If previous midline scar, attempt entry in an area above or below the scar to avoid any underlying adhesions.
- Perform lysis of adhesions if needed to obtain good exposure.
- Position the abdominal wall retractor and explore for any undiagnosed pathology.
- Protect and pack the small bowel using moist towels to the left of the abdomen.

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## Dissection, Resection, and Reconstruction

Dissection, resection, and reconstruction steps are similar to the laparoscopic approach as described in Chap. 14.

*Main steps are summarized as follows:*

- Mobilize the cecum and ascending colon to the hepatic flexure.
- Mobilize the proximal transverse colon by dividing the gastrocolic ligament and entering the lesser sac.

** It is important to visualize the posterior part of the stomach to ensure that the lesser sac has been entered**

- Identify and ligate the ileocolic vessels at their origin – if cancer operation.
- Divide the mesentery, including the right colic and right branch of the middle colic artery, preserving the middle colic artery.
- Transect the terminal ileum (10 cm proximal to the ileocecal valve) and the proximal transverse colon (proximal and distal margin).
- Create an isoperistaltic or antiperistaltic ileocolic anastomosis (surgeon preference).

## Access Reader Checklist Appendix

### ☑ READER CHECKLIST
### Open Right Hemicolectomy

#### ☑ PREFERENCE CARD

►**Instruments**
__Number 10-blade scalpel with handle
__Abdominal wall retractor (surgeon preference: Bookwalter, Thompson, Balfour, large or extra-large wound protector)
__Toothed and non-toothed forceps (Adson Brown, Debakey, Rat tooth, Bonney)
__Curved Metzembaum and Mayo scissors
__Electrocautery, vessel sealing device
__Kocher, Allis and Babcock clamps
__Kelly, Mosquito hemostats
__Retractors (Richardson, Deaver, Army Navy)
__Needle drivers
__Linear cutting stapler
__Suction

►Sutures
__0 polyglactin ties
__2/3.0 polyglactin
__3.0 polydioxanone
__1 looped polydioxanone
__Skin stapler or 2-0 non-absorbable sutures for skin closure

#### ☑ PATIENT POSITIONING/ OPERATING ROOM SETUP

►Patient Positioning
__Modified lithotomy position with legs in stirrups to provide easy access to perineal region (in case intraoperative colonoscopy needed)
__Thighs flexed
__Abduct and secure arms on padded arm boards (max 90 degrees)
__Prep and drape abdomen
__Perineal region does not need to be prepped, but easily accessible

►Operating Room Setup
__Surgeon is positioned to patient's right
__Assistant stands to patient's left
__Second assistant can stand either to left of first assistant or between patient's legs
__Scrub nurse is to right of surgeon
__Insert Foley catheter

#### ☑ NODAL POINTS

►**Type of Incision**
__Midline skin incision above and below umbilicus using 10-blade scalpel, extending cranially or caudally, if needed

►**Approach**
__Obtain controlled entry into abdomen.
__If previous midline scar, attempt entry in area above or below scar to avoid underlying adhesions
__Perform lysis of adhesions, if needed, to obtain good exposure
__Position abdominal wall retractor and explore for any undiagnosed pathology
__Protect and pack small bowel using moist towels to left of abdomen

►**Dissection, Resection, and Reconstruction**
__Dissection, resection and reconstruction steps similar to laparoscopic approach as described in Chapter 14.

**Main steps:**
__Mobilize cecum and ascending colon to hepatic flexure
__Mobilize proximal transverse colon by dividing gastrocolic ligament and entering lesser sac
__Important to visualize posterior part of stomach to ensure lesser sac has been entered
__Identify and ligate ileocolic vessels at their origin – if cancer operation
__Divide mesentery, including right colic and right branch of middle colic artery, preserving middle colic artery
__Transect terminal ileum (10 cm proximal to ileocecal valve) and proximal transverse colon (proximal and distal margin)
__Create isoperistaltic or antiperistaltic ileocolic anastomosis (surgeon preference)