Operative note (Hernia) Phen Hospital

Date of operation.....Time started.....Time ended.....
Surgeon..... First Assistant..... Second assistant.....
Clinical diagnosis.....
Post operative diagnosis.....
Operative procedure.....
Anesthesia..... Anesthetist..... Scrub nurse.....

Finding

Position .....supine..... ☐ Other.....

Procedure

- The skin incision was made superior to the inguinal ligament.
- Electrocautery was used to dissect through Scarpa's and Camper's fascia down to the external oblique aponeurosis.
- The external oblique aponeurosis was opened in the direction of its fibers through the external ring using a scalpel/Metzenbaum scissors.
- The ilioinguinal nerve was identified and ported from injury.
- The inguinal floor was exposed by creating superior and inferior flaps of the external oblique.
- The spermatic cord was idented and mobilized at the pubic tubercle then isolated using a

☐ Cord tape ☐ pen rose drain ☐ other.....

☐

-The anteromedial aspect of the cord was examined and an indirect hernia sac was idented.
- The sac was carefully dissected free of the cord down to the level of the internal ring.
- The sac was twisted and suture ligated with 2-0 silk suture.
- Any redundant sac was excised using electrocautery.
- The stump of the sac was checked for hemostasis and allowed to retract into the abdomen.

(In case indirect inguinal hernia)

-To repair the floor of the canal, a mesh was cut to appropriate size.
- Starting at the pubic tubercle, the mesh was secured flat with interrupted 2-O vicryl sutures to the reflected edge of the inguinal ligament inferiorly, the conjoint tendon superiorly.

☐ In case that secure by Protack autosuture
☐ Place mesh without suture.

The cord tape was removed and the cord itself was returned to its anatomic location above the mesh.
- Hemostasis was achieved using electrocautery.
- The external oblique aponeurosis was re-approximated using a vicryl suture.
- The skin was closed by .....

Note.....
EBL.....ml .....
☐ Tissue for Patho..... .....
Intra-operative complication ☐ No ☐ Yes..... .....

Name of patient	Age year Mo. Day	HN..... AN.....
Surgeon	Ward	Department