

# TLC Surgical Center

240 S Laci enaga Blvd

Suite 210

Beverly Hills, CA 90211

**PATIENT:** Christine Keenan

**DATE OF PROCEDURE:** Wednesday, September 14th, 2022

**ABDOMINAL PREOPERATIVE DIAGNOSIS:** Abdominal Lip edema/Dercums

**ABDOMINAL POSTOPERATIVE DIAGNOSIS:** Same

**ABDOMINAL PROCEDURE:** Lip edema/Dercums Excision with Full thickness subcutaneous tissue removal.

**SURGEON:** Jaime S Schwartz, MD FACS

**ANESTHESIOLOGIST:** Lauren Johnson, CRNA

**ANESTHESIA:** TIVA

**PREOPERATIVE MEDICATIONS:** Ancef 2gms prior and 1gm q4 during procedure

**ESTIMATED BLOOD LOSS:** Minimal

**SPECIMEN:** None

**FINDINGS:** Full thickness disease tissue intertwined with the dermis and the deep fascia of your domino wall. There is no way to separate or find any normal planes.

**DRAINS:** 1 10 french

**COMPLICATIONS:** None

**DISPOSITION:** Stable to recovery care unit.

## INDICATIONS FOR ABDOMINAL PROCEDURE:

Christine Keenan is a 57 year old female who presents with severe abdominal lip edema and dercums causing an immense amount of pain that has not been relieved by any conservative measures. The scheduled procedure is Lip edema/Dercums Excision with Full thickness subcutaneous tissue removal.

## ABDOMINAL RISKS:

The patient was seen in the preoperative area with the OR nurse and a chaperone if indicated as well as preoperative photographs. The patient performed surgical site confirmation in a mirror and concurred with the markings. These were then photographed. It was discussed with a patient that she is extremely high risk for complications given the fact that she has Dercum's disease and lip edema as well as had previous abdominal surgeries including an extremely large cholecystectomy scar.

The risks, benefits, expectations and alternatives of were discussed with the patient including, but not limited to, infection, bleeding, deep injury to nerves, blood vessels or other structures such as umbilicus, injury to abdominal or thoracic viscera, seroma, deep venous thrombosis, delayed healing, visible scarring, contour irregularities, color change, asymmetry, loss of skin, cosmetic dissatisfaction, recurrence, blood loss, vasovagal symptoms, scarring at incisions, anesthesia reaction, dysesthesia, as well as unplanned return to the operating room. Complication risk is higher if any of the treatment areas have had previous interventions. We discussed at length that abdominoplasty deals with the anterior abdomen only. Liposuction of the flanks will be performed but this does not guarantee there will not be excess skin or fat laterally or posteriorly. In order to make the anterior abdomen as tight and flat as possible given the anatomy, pulling excessively laterally and posteriorly can cause tension in the wrong direction and possibly increased risk for wound healing complications. It is safer to perform a secondary flank plasty or posterior body lift to bring the waist in. This procedure can only be performed as far posterior as the OR table will allow. The patient read and signed the consent form and verbalized full understanding.

## GENERAL PROCEDURE:

Under full, informed consent, the patient was brought to the operating room. A Bair hugger was applied to keep the patient warm. TED hose and SCDS were applied to the lower extremities bilaterally for DVT prophylaxis prior to induction of anesthesia if possible. Full continuous cardiac monitoring and automated blood-pressure measurements were performed per protocol. The patient was placed in the supine (with the arms outstretched) position. The patient underwent administration of anesthesia. Surgical site preparation was performed with Hibiclens and draping was performed in standard sterile fashion. A Time-out was performed per protocol verifying the names of the patient and surgeon, the operative sites, and the operative plan per the informed consent. All staff in the room verified the information and site(s) as correct. Universal PAUSE Rule was fulfilled.

## ABDOMINAL PROCEDURE:

The proposed incision was checked for symmetry. Incisions were made and tumescent solution was infiltrated into the treatment area evenly until satisfactory tissue turgor was achieved. Once this was completed the lower abdominal incision was made. The incision was dissected superiorly trying to separate the diseased subcutaneous tissue from the dermis. Of note the disease tissue is full thickness the innards fine with the dermis as well as the deep fascia of the abdominal wall. There are no normal planes to find or follow. Due to this the section was limited to the lower portion of the abdomen where she states she has the most pain. Once the superficial dissection was complete the lower abdominal incision was deepened to the deep fascia. This dissection was likewise taken superiorly to remove as much of the disease tissue as possible en bloc. Hemostasis was checked and achieved. Quilting sutures were placed advancing the flap and closing off the dead space. The incision was closed in layers and covered with sterile and waterproof dressing as well as light compression garment.

There were no complications during the procedure and all needle and sponge counts were correct.

The patient was moved to the recovery area in satisfactory condition.

Area	Fluid In	LSL Out	MLE Out	Total	Fibrotic	Bleeding	MLE Easy	LSL Easy
------	----------	---------	---------	-------	----------	----------	----------	----------

Left Leg	750cc	500cc	75cc					
Right Leg	580cc	400cc	50cc					
Left Thigh	1300cc	500cc						
Right Thigh	1160cc	200cc						
Abdomen	1600cc	900cc		Tissue excision weight = 1 lb				
Total	5390cc	2500cc	125cc					