PROCEDURAL STEPS

Indirect inguinal hernia mesh repair in men

- Incise the skin in the groin for 5–6 cm within a Langer line to expose the internal ring
- Deepen the incision through the subcutaneous tissue to expose the external oblique fascia
- Open the external oblique aponeurosis and free its lower leaf from the spermatic cord
- Free the upper leaf of the external oblique aponeurosis from the underlying muscle
- Separate the spermatic cord and encircle it with a Penrose drain
- Incise the cremasteric sheath to explore the internal ring for an indirect hernia sac
- Free, if present, the indirect hernia sac from the cord to a point beyond the neck of the sac
- Verify that the sac is empty, then suture ligate the sac and transect it
- Invert the indirect hernia sac into the peritoneal space
- Select a mesh to insert, retract the spermatic cord
- Suture the mesh to the insertion of the rectus sheath to the pubic bone
- Continue the suture to attach the lower edge of the patch to the inguinal ligament up to a point just lateral to the internal ring
- Suture the upper edge of the mesh to Cooper’s ligament
- Place the spermatic cord between the mesh tails
- Wrap the tails around the cord and place a suture to secure them there
- Tuck the excess mesh underneath the external oblique aponeurosis
- Close the external oblique aponeurosis over the cord with an absorbable suture
- Close the skin with an absorbable suture

Committed: __
Omitted: ____

Total: _____/18

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**Laparoscopic cholecystectomy**

- Incise the skin 2-cm length above or below the umbilicus
- Incise the linea alba to enter the abdomen and place stay sutures in the fascia
- Place a primary 10-mm Hasson trocar through the umbilicus
- Begin gas insufflation and pass a laparoscope through Hasson
- Place a second 5-mm trocar in the epigastrium under direct vision, at the level of the inferior liver edge just to the right of the falciform ligament, angling toward the gallbladder
- Place a third 5-mm trocar just below the costal margin in the midclavicular line
- Place a fourth trocar in a variable position, generally in the anterior axillary line, several centimeters below the fundus of the gallbladder
- Elevate the gallbladder by placing a clamp on the fundus of the gallbladder and elevate the fundus
- Dissect the peritoneum at the interface between Hartman’s pouch and periportal fat toward the common duct until the cystic duct, cystic artery, or lymph node of Calot is identifiable
- Circumferentially dissect the cystic duct as it enters the gallbladder to achieve the critical view of safety. Ligate and divide the cystic duct
- Circumferentially dissect the cystic artery as it crosses onto the gallbladder to achieve the critical view of safety. Ligate and divide the cystic artery
- Dissect the gallbladder off the liver bed using traction and cautery, ensuring hemostasis
- Move the laparoscope to the epigastric trocar and place the gallbladder into an endobag introduced through the Hasson trocar
- Remove both the trocar and the gallbladder
- Remove trocars (under direct vision)
- Close fascia and skin

**Committed: **

**Omitted:**

**Total: **(____/16)
Open right hemicolecotomy for malignancy

- Make a midline incision
- Perform a full laparotomy
- Locate the site of the malignancy
- Open the retroperitoneum along the white line of Toldt to separate the retroperitoneal structures from the terminal ileum and colon
- Incise the medial and inferior attachments to the cecum and terminal small bowel toward the junction of the third and fourth portions of the duodenum
- Continue the lateral dissection up and around the hepatic flexure, retracting the midtransverse colon inferiorly
- Dissect the thin plane between the mesocolon and the gastrocolic ligament to complete the flexure mobilization.
- Ligate and divide vessels as needed
- Place a gentle traction on the transverse colon and complete the remaining mobilization of the proximal transverse colon.
- Retract the right colon superio-medially, exposing the duodenum and head of the pancreas
- Incise the peritoneum overlying the mesenteric vasculature
- Clamp, divide and ligate the ileocolic and right branch of the middle colic vessels at their base
- Clamp and divide the marginal branches to the ileum at the proximal margin of resection
- Divide the terminal ileum (using stapling device or clamp and sharp incision)
- Divide the colon (using stapling device or clamp and sharp incision)
- Send the specimen for pathologic evaluation
- Align the bowel and perform the anastomosis
- If hand sawn → 2 layers closure
- If stapled → GIA between colon and small bowel with mesenteric border
- Close with T-A stapler after aligning with Alice clamps or 2-layer closure
- Check the abdomen for adequate hemostasis
- Close abdomen at fascia and skin

Committed: ___
Omitted: _____

Total: _____/19