FEATHER RIVER HOSPITAL

5974 Pentz Road
Paradise, CA 95969
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Operative Summary

Patient:	PATIENT F AA
Birthdate:	09/01/1951
Medical Record #:	1234
Pre-Operative Diagnosis:	Left inguinal hernia [550.90]
Procedure:	Left Inguinal Herniorrhaphy with Mesh [49505-Lt]
Post-Operative Diagnosis:	Left Inguinal Hernia
Surgeon:	Lyle B. Hunt, M.D.
Assistant:	No Assistant cc: Gregory Davis, M.D.
Anesthesiologist:	Timothy Gleason, M.D.
Anesthetic:	Regional Local
Date:	11/13/2007

Surgical Indications: The patient is a 56 year old Caucasian male seen for evaluation of left groin pain and left groin hernia. He is seen at the request of Dr. Gregory Davis. He denies any prior hernia surgery. The symptoms are aggravated by coughing. The symptoms are aggravated by lifting. The symptoms are aggravated by sneezing.

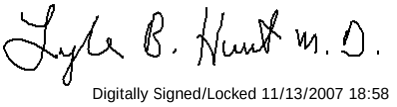
Description of Procedure: After positioning in the supine position the left groin was prepped and draped in a sterile manner. Anesthesia was induced. An incision in the left groin crease was made and extended down to the external oblique fascia. The external oblique fascia was divided in the direction of its fibers. The ilioinguinal nerve was identified and preserved. Control of the cord structures was obtained at the pubic tubercle.

The cord was skeletonized and an indirect inguinal hernia sac was identified. This was opened and a finger passed into the abdomen. There was no evidence of a femoral hernia. The hernia sac was suture ligated with a 2-0 Vicryl and the residual sac resected.

The floor of Hesselbach's triangle was attenuated consistent with a direct inguinal hernia. This was closed with a #1 Vicryl. The floor was further re-enforced with a 2x4 inch sheet of Marlex mesh. A lateral slit being made. The mesh was sewn in place with 2-0 Prolene. The newly created internal ring would admit the hemostats but not my small finger.

The wound was irrigated and hemostasis was obtained. The external oblique was closed over the cord and cord structures using a 2-0 Vicryl stitch. Care was taken to avoid the underlying nerve and cord structures. The subcutaneous tissue was closed with a 3-0 Vicryl stitch. The skin was re-approximated with a 4-0 Monocryl stitch in subcuticular fashion.

Dressings were applied. The patient tolerated the procedure well.



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Lyle B. Hunt, M.D.

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