

**MODERNISING  
MEDICAL CAREERS**

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# How to write a surgical operation note

## Introduction

The surgical operation note is an important legal document that should provide details of the surgical procedure performed as well as guide management of the patient in the early postoperative period. Completion of the operation note is mandatory and should be per-

formed promptly and accurately. However, little formal training exists in this area and most surgical trainees are left to learn the process independently. This article offers a simple and structured guide to filling out an operation note, particularly for those beginning their surgical training, and includes an example of an operation note written in this manner (*Figure 1*).

## The obvious details

Most centres will provide a separate operation note to complete, often specifying the relevant sections to fill out, while others will expect the details of the operation

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**Figure 1. Example of an operation note.**

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Open appendicectomy	
Surgeons: Mr J Smith, Dr M Bloggs	
Anaesthetist: Dr R Jones	
Scrub Nurse: T Jackson	
Indication:	Right iliac fossa pain with fever and leucocytosis. Suspected appendicitis
Anaesthetic:	General
Position:	Supine
Incision:	Lanz Skin and subcutaneous tissues divided. External oblique aponeurosis divided along length of its fibres. Internal oblique divided using muscle splitting incision. Peritoneum exposed and incised.
Findings:	Small quantity (less than 10 ml) of purulent fluid in abdominal cavity around appendix base. Caecum identified by virtue of taenia coli and appendix delivered. Grossly inflamed appendix with small area of localised perforation around the tip. No other abnormalities identified.
Procedure:	Adhesions between appendix and surrounding tissue divided. Mesoappendix ligated with 3.0 Vicryl and divided. Appendix base crushed, ligated with 3.0 Vicryl then divided. Appendix sent for histology. Appendix stump buried with 3.0 Vicryl. Peritoneal cavity washed out with 1 litre of warm normal saline. Peritoneum, internal oblique and external oblique closed with 3.0 Vicryl. 3.0 monocryl subcuticular stitch to skin.
Postoperative instructions:	Can eat, drink and mobilise. Analgesia as required (paracetamol and tramadol prescribed). 7 days of antibiotics (initially intravenous then convert to oral when discharged home). Sutures are absorbable. Please contact doctor if pain not sufficiently controlled or observations change (temperature >38°C, heart rate >100, systolic blood pressure <90 and urine output <30 ml/hour)

to be documented within the patient's notes. Increasingly, many institutions are using electronic systems in theatres where the surgeon can enter the details of the operation into a computer program as part of an electronic patient record. This can also be printed off and placed in the notes. As with most things, check the local hospital policy.

Fill in all the relevant details of the patient including his/her hospital number and date of birth. If you are using a patient label, ensure that it belongs to the patient – occasionally labels can end up in the wrong patient's notes.

All the participants directly involved in the operation should be documented. By convention, on the operating side, this will include the name of the lead surgeon first, followed by the assistants in order of greatest contribution (e.g. first assistant, second assistant). The name of the anaesthetist should also be recorded, particularly as he/she should be approached directly after the operation if there are any concerns regarding pain control or ongoing symptoms related to the anaesthesia. The details of the participating scrub nurse are often left out, but his/her contribution to the operation is just as crucial and he/she can be an important additional source of contact regarding any details of the operation such as patient safety issues or any adverse events that may arise during the operation, e.g. retained swabs or equipment.

### Name of the operation

This should be written in full, avoiding abbreviations in the first instance, e.g. laparoscopic right hemicolectomy rather than Lap R hemi.

### Indication for the operation

In very brief terms, the reason for the procedure should be documented, for example, for an appendicectomy, this could be: 'right iliac fossa pain with fever and raised white cell count. Suspected appendicitis.'

### Position of the patient

The position of the patient is one of the most important aspects of the preoperative preparation of the patient and will vary depending on the procedure being performed.

Medicolegally, documentation of the patient's position is important as it indicates that the patient was positioned in the most appropriate position for access and exposure as well to minimize adverse events such as nerve injuries and pressure ulcers. Specific complications are associated with certain positions and these may be anticipated or explained if the patient position has been documented, e.g. hip dislocation and common peroneal nerve damage with the lithotomy position; brachial plexus injury with excessive traction of the arm at the axilla.

Table 1 shows the common positions encountered in general surgical procedures along with a brief explanation.

### Incision

The opening incision should be documented as well as its laterality. Many incisions have notable names and it is acceptable to use these in the operation note.

Figure 2 shows the common incisions used in general surgical procedures.

Specific anatomical details of the operation may be recorded in this section such as the tissue layers encountered and divided en route to the area of interest.

### Findings

This section should document the pathological findings from the operation as well as any important negative findings.

Depending on the findings, this should include details such as the site, size, colour, volume or percentage of structure involved, e.g. 5 cm ulcerated mass found on the lateral aspect of the sigmoid colon, adherent to the lateral abdominal wall.

## KEY POINTS

- The surgical operation note is an important legal document which must be completed after every surgical procedure.
- It should provide an accurate record of the surgical intervention performed and guide postoperative management of the patient.
- The operation note should generally the same format: incision, findings, procedure and postoperative instructions
- Postoperative instructions should pay particular attention to nutrition, antibiotic use, analgesia, removal of sutures, drains and dressings.
- All the participants of the operation should be documented: surgeons, anaesthetist and scrub nurse.

**Table 1. Common surgical patient positions**

Patient position	Description
Supine (most abdominal procedures, e.g. laparotomy, appendicectomy)	Lying flat on back
Lithotomy (perineal surgery)	Lying flat on back. Knees bent and positioned above the hips, and spread apart using stirrups
Trendelenburg (e.g. laparoscopic cholecystectomy initially)	Lying flat with feet higher than head
Reverse Trendelenburg (e.g. laparoscopic cholecystectomy following Trendelenburg)	Lying flat with head higher than feet
Lloyd–Davies (perineal surgery, e.g. abdomino-perineal resection)	Lying in Trendelenburg position with slight flexion of hips
Lateral position	Lying on right or left side to expose contralateral side, e.g. nephrectomy, hip surgery
Prone position	Lying face down, e.g. spinal surgery
Supine position with arm abducted	To expose axilla, e.g. axillary node clearance; to position limb for hand or arm surgery

## Procedure

This section concerns the surgical steps undertaken to address the pathological findings as well as the justification for this decision making.

Reference should be made to the use and positioning of drains as well as the suture material to close the various anatomical layers.

At this point, the use of diagrams can sometimes help to explain the operative findings as well as demonstrate the subsequent surgical steps undertaken.

## Postoperative management

Arguably, the most important part of the operation note, this section provides important guidelines in managing the

patient in the postoperative period. Particular attention should be paid to:

- Nutrition (when can the patient eat and drink?)
- Analgesia
- Medications, e.g. antibiotic therapy and duration
- When sutures should be removed if relevant
- When drains should be removed (e.g. less than 50 ml over 24 hours)
- Details of specific dressings or devices if appropriate, e.g. VAC dressings, plasters, splints, alginate dressings. It is important to state when these should be changed or can be removed and by whom, e.g. district nurse, special dressing clinic, on the ward round by doctors
- Specific nursing instructions, e.g. limb elevation, bed rest, nurse head up
- Specialist input required, e.g. physiotherapy, tissue viability nurse, dietician, occupational therapist
- Blood tests (e.g. checking calcium levels post thyroidectomy).

## And finally...

Don't forget to print your name (legibly so you can be identified), sign the note and write your contact details, e.g. bleep number. [BJHM](#)

*Conflict of interest: none.*

**Figure 2. Common general surgical incisions or scars of the abdomen. GI = gastrointestinal.**

