**OPERATIVE REPORT – CELIAC PLEXUS BLOCK**

FACILITY:

PATIENT:

DATE OF BIRTH / MEDICAL RECORD NUMBER:

DATE of PROCEDURE:

ATTENDING:

ASSISTANT:

PREOPERATIVE DIAGNOSIS:

[1. Malignant neoplasm of the pancreas: ICD-10 C25.9]

[2. Chronic abdominal pain: ICD-10 R10.9]

POSTOPERATIVE DIAGNOSIS:

[1. Malignant neoplasm of the pancreas: ICD-10 C25.9]

[2. Chronic abdominal pain: ICD-10 R10.9]

PROCEDURE:

Celiac plexus block with fluoroscopy (CPT 64530)

INDICATION:

ANESTHESIA:

TECHNIQUE:

A description of the procedure and its risks, benefits, and alternatives, were provided to the patient and informed consent was obtained prior to procedure commencement. The patient was taken to the operating room and carefully placed in the prone position. The back was prepped and draped in sterile fashion. A time was convened. Fluoroscopy was utilized to identify the T12-L1 junction in anteroposterior view. The C-arm was positioned in oblique view toward the left to place the left transverse process of L1 with overlay to the lateral border of vertebral body. Local injection of lidocaine 1% was administered at the skin with a 30g needle and to the subcutaneous tissue just above the transverse process of L1 just lateral to the vertebral body. Then, a 7 inch 22-gauge spinal needle was advanced parallel to the angle of the C-arm toward the lateral body of L1 above its transverse process until it contacted bone. The C-arm was then put into a lateral position and the needle was walked off and advanced until the needle tip was anterior to the L1 vertebral body. A t-connector with contrast was connected to the needle and aspirated for blood. When found to have blood return, the needle was advanced until there was no blood return. Contrast was injected to ensure no vascular uptake. Then, after injecting 3cc of a solution of bupivacaine 0.25% with epinephrine 1:200000 without any significant hemodynamic change, the remainder of the 30cc solution was injected with negative aspiration at each 5cc increment. The needle was removed, hemostasis was achieved, and a bandage applied.

The patient tolerated the procedure well, with no complication, and was taken to the recovery area in stable condition. The patient was observed in the recovery area for an appropriate period of time, discharged to home in stable condition with careful precautions, with follow-up in the office and availability by telephone for advisement if needed.