PREOPERATIVE DIAGNOSIS: ,Persistent abnormal uterine bleeding after endometrial ablation.,POSTOPERATIVE DIAGNOSIS: , Persistent abnormal uterine bleeding after endometrial ablation.,PROCEDURE PERFORMED: , Total abdominal hysterectomy (TAH) with a right salpingo-oophorectomy.,COMPLICATIONS: , None.,ESTIMATED BLOOD LOSS: , 250 cc.,FLUIDS: ,1500 cc of crystalloids.,URINE: , 125 cc of clear urine at the end of the procedure.,FINDINGS: , On exam, under anesthesia, an obese female with an enlarged fibroid uterus freely movable on the pelvis. Operative findings demonstrated the same with normal appearing tubes bilaterally. The right ovary contained a right ovarian cyst. The left ovary appeared to be within normal limits. The peritoneal surfaces were noted to be within normal limits. The bowel was also noted to be within normal limits.,INDICATIONS FOR THIS PROCEDURE: , The patient is a 44-year-old female who had an endometrial ablation done in May, which showed submucosal fibroids. She had history of anemia and has been on iron therapy. She started having bleeding three weeks ago with intermittent bouts of flooding.,She desired permanent and definitive therapy and therefore it was felt very appropriate to take the patient for a total abdominal hysterectomy. The uterus, cervix, and right tube and ovary was sent to pathology for review.,PROCEDURE: , After informed consent was obtained, all questions were answered to the patient's satisfaction in layman's term. She was taken to the operating room where a general anesthesia was obtained without any difficulty. She

was examined under anesthesia with noted findings above. She was placed in a dorsal supine position and prepped and draped in the usual sterile fashion. The Pfannenstiel skin incision was made with the first knife and was then carried down to the underlying layer of the fascia. With the second knife, the fascia was excised in the midline and extended laterally with the Mayo scissors. The superior aspect of the fascial incision was then tented up with the Ochsner clamps and the underlying rectus muscle was dissected off sharply as well as bluntly. Attention was then turned to the inferior aspect of the fascial incision, which in a similar fashion was tented up and the underlying rectus muscle was dissected off sharply as well as bluntly. The rectus muscle was then separated in the midline, the peritoneum was identified, entered bluntly and digitally. Then the peritoneal incision was then extended superior and inferiorly with excellent visualization of the bladder. The GYN Balfour was then placed. A Lahey clamp was placed on the fundus of the uterus to pull the uterus into the operative field and the bowel was packed away with moist laparotomy sponges. Attention was then turned to the round ligaments bilaterally, which were tented up with Allis clamps and then a hemostat was poked through the avascular portion underneath the round ligament and the #O-tie was passed through and then tied down. Then the round ligament was transected and suture ligated and noted to be hemostatic. The round ligaments were then skeletonized to create a window in the broad ligament. The right infundibulopelvic ligament was isolated through the window created from the round ligaments

and then the infundibular ligament on the right was loop tied and then doubly clamped with straight Ochsner clamps and then transected and suture ligated with a #0 Vicryl in a Heaney stitch fashion. It was noted to be hemostatic. Attention was then turned to the left side, in which the uterovarian vessel was isolated and then tied with an #O-tie and then doubly clamped with straight Ochsner clamps, transected and suture ligated with a #0 Vicryl in a Heaney stitch fashion and noted to be hemostatic. The vesicouterine peritoneum was then identified, tented up with Allis clamps, and then the bladder flap was created sharply with a Russian and Metzenbaum scissors. Then the bladder was deflected off of the underlying cervix with blunt dissection with a moist Ray-Tec sponge down to the level of the cervix.,The uterine vessels were skeletonized bilaterally and then clamped with straight Ochsner clamps and transected and suture ligated and noted to be hemostatic. In the similar fashion, the broad ligament down to the level of the caudal ligament, the uterosacral ligaments was clamped with curved Ochsner clamps and transected and suture ligated, and noted to be hemostatic. The second Lahey clamp was then placed on the cervix. The cervix was tented up and the pubocervical vesical fascia was transected with a long knife and then the vagina was entered with a double pointed scissors poked through well protecting posteriorly with a large malleable. The cuff was then outlined. The vaginal cuff was grasped with a Ochsner clamp and then the cervix, uterus, and the right tube and ovary were transected using the Jorgenson scissors. The cuff

outlined with Ochsner clamps. The cuff was then painted with a Betadine soaked Ray-Tec sponge and the sponge was placed over the vagina. The vaginal cuff was then closed with a #0 Vicryl in a running locked fashion holding on to the beginning end on the right side as well as incorporating the ipsilateral cardinal ligaments into the cuff angles. A long Allis was then used to grasp the mid portion of the cuff and a #0 Vicryl figure-of-eight stitch was placed in the mid portion of the cuff and tied down. At this time, the abdomen was copiously irrigated with warm normal saline and noted to be hemostatic. The suture that was used to close the cuff was then used to come back through the posterior peritoneum grabbing the uterosacral ligaments and the mid portion of the cuff, and then tied down to bring the cuff close and together. Then, the right round ligament was pulled into the cuff and tied down with the #0 Vicryl that was used as a figure-of-eight stitch in the middle of the cuff. The left round ligament was too small to reach the cuff. The abdomen was then again copiously irrigated with warm normal saline and noted to be hemostatic. The peritoneum was then re-peritonealized with a #3-0 Vicryl in a running fashion. The GYN Balfour and all packing sponges were removed from the abdomen. Then the abdomen was then once again copiously irrigated and the cuff and incision sites were once again reinspected and noted to be hemostatic. The _____ was placed back into the hollow of the sacrum. The omentum was then pulled over to top of the bowel and then the peritoneum was then closed with a #3-0 Vicryl in a running fashion and then the fascia was closed with

#0 Vicryl in a running fashion. The skin was closed with staples and dressing applied. The patient was then examined at the end of the procedure. The Betadine-soaked sponge was removed from the vagina. The cuff was noted to be intact without bleeding and the patient tolerated the procedure well. Sponge, lap, and needle counts were correct x2 and she was taken to the recovery in stable condition. The patient will be followed throughout her hospital stay.