PREOPERATIVE DIAGNOSES:,1.Stage IV endometriosis with severe pelvic pain.,2.Status post prior left salpingoophorectomy.,POSTOPERATIVE DIAGNOSES:,1.Stage IV endometriosis with severe pelvic pain.,2.Status post prior left salpingoophorectomy.,3.Severe adhesions.,TYPE OF ANESTHESIA: , General endotracheal tube.,TECHNICAL PROCEDURE: , Total abdominal hysterectomy, right salpingoophorectomy, and extensive adhesiolysis and enterolysis.,INDICATION FOR PROCEDURE: , The patient is a 42-year-old parous female who had a longstanding history of severe endometriosis unresponsive to hormonal medical therapy and pain medication. She had severe dyspareunia and chronic suprapelvic pain. The patient had had a prior left salpingoophorectomy laparoscopically in 2004 for same disease process. Now, she presented with a recurrent right ovarian endometrioma and severe pelvic pain. She desired surgical treatment. She accepted risk of a complete hysterectomy and salpingoophorectomy, risk of injury to underlying organs. The risks, benefits, and alternatives were clearly discussed with the patient as documented in the medical record.,DESCRIPTION OF FINDINGS: , Absent left adnexa. Right ovary about 6 cm with chocolate cyst and severely adherent to the right pelvic side wall, uterus, and colon. Careful dissection to free right ovary and remove it although it is likely that some ovarian tissue remains behind. Ureter visualized and palpated on right and appears normal. Indigo carmine given IV with no leaks intraperitoneally noted.

Sigmoid colon dissected free from back of uterus and from cul-de-sac. Bowel free of lacerations or denudation. Upon inspection, right tube with hydrosalpinx, appendix absent. Omental adhesions to ensure abdominal wall was lysed.,TECHNICAL PROCEDURE: , After informed consent was obtained, the patient was taken to the operating room where she underwent smooth induction of general anesthesia. She was placed in a supine position with a transurethral Foley in place and compression stockings in place. The abdomen and vagina were thoroughly prepped and draped in the usual sterile fashion.,A Pfannenstiel skin incision was made with the scalpel and carried down sharply to the underlying layer of fascia and peritoneum. The peritoneum was bluntly entered and the incision extended caudally and cephaladly with good visualization of underlying organs. Next, exploration of the abdominal and pelvic organs revealed the above noted findings. The uterus was enlarged and probably contained adenomyosis. There were dense adhesions, and a large right endometrioma with a chocolate cyst-like material contained within. The sigmoid colon was densely adhered to the cul-de-sac into the posterior aspect of the uterus. A Bookwalter retractor was placed into the incision, and the bowel was packed away with moist laparotomy sponges. Next, a sharp and blunt dissection was used to free the extensive adhesions, and enterolysis was performed with very careful attention not to injure or denude the bowel. Next, the left round ligament and cornual region was divided, transected, and suture-ligated with 0 Polysorb. The anterior

and posterior leafs of the broad ligament were dissected and opened anteriorly to the level of the bladder. The uterine arteries were skeletonized on the left, and these were suture-clamped and transected with 0 Polysorb with good hemostasis noted. Next, the bladder flap was developed anteriorly, and the bladder peritoneum was sharply and bluntly dissected off of the lower uterus.,On the right, a similar procedure was performed. The right round ligament was suture-ligated with 0 Polysorb. It was transected and divided with electrocautery. The anterior and posterior leafs of the broad ligament were dissected and developed anteriorly and posteriorly, and this area was relatively avascular. The left infundibulopelvic ligament was identified. It was cross-clamped and transected, suture-ligated with 0 Polysorb with good hemostasis noted. Next, the uterine arteries were skeletonized on the right. They were transected and suture-ligated with 0 Polysorb. The uterosacral ligaments were taken bilaterally and transected and suture-ligated with 0 Polysorb. The cardinal ligaments were taken near their insertion into the cervical and uterine tissue. Pedicles were sharply developed and suture-ligated with 0 Polysorb. Next, the electrocautery was used to dissect the cervix anteriorly from the underlying vagina. Once entry into the vagina was made, the cervix and uterus were amputated with Jorgensen scissors. The vaginal cuff angles were suture-ligated with 0 Polysorb and transfixed to the ipsilateral, cardinal, and uterosacral ligaments for vaginal support. The remainder of the vagina was closed with figure-of-eight sutures in an

interrupted fashion with good hemostasis noted.,Next, the right ovarian tissue was densely adherent to the colon. It was sharply and bluntly dissected, and most of the right ovary and endometrioma was removed and dissected off completely; however, there is a quite possibility that small remnants of ovarian tissue were left behind. The right ureter was seen and palpated. It did not appear to be dilated and had good peristalsis noted. Next, the retractors were removed. The laparotomy sponges were removed from the abdomen. The rectus fascia was closed with 0 Polysorb in a continuous running fashion with 2 sutures meeting in the midline. The subcutaneous tissue was closed with 0 plain gut in an interrupted fashion. The skin was closed with 4-0 Polysorb in a subcuticular fashion. A thin layer of Dermabond was placed.,The patient tolerated the procedure well. Sponge, lap, and needle counts were correct x 2. Cefoxitin 2 g was given preoperatively.,INTRAOPERATIVE COMPLICATIONS:, None.,DESCRIPTION OF SPECIMEN: , Uterus and right adnexa.,ESTIMATED BLOOD LOSS: , 1000 mL.,POSTOPERATIVE CONDITION: , Stable.,