PREOPERATIVE DIAGNOSIS:, Endometrial carcinoma.,POSTOPERATIVE DIAGNOSIS: , Endometrial carcinoma.,PROCEDURE PERFORMED:, Total laparoscopic hysterectomy with laparoscopic staging, including paraaortic lymphadenectomy, bilateral pelvic and obturator lymphadenectomy, and washings.,ANESTHESIA: , General, endotracheal tube.,SPECIMENS: , Pelvic washings for cytology; uterus with attached right tube and ovary; pelvic and paraaortic lymph node dissection; obturator lymph node dissection.,INDICATIONS FOR PROCEDURE: , The patient was recently found to have a grade II endometrial cancer. She was counseled to undergo laparoscopic staging.,FINDINGS:, During the laparoscopy, the uterus was noted to be upper limits of normal size, with a normal-appearing right fallopian tubes and ovaries. No ascites was present. On assessment of the upper abdomen, the stomach, diaphragm, liver, gallbladder, spleen, omentum, and peritoneal surfaces of the bowel, were all unremarkable in appearance.,PROCEDURE: , The patient was brought into the operating room with an intravenous line in placed, and anesthetic was administered. She was placed in a low anterior lithotomy position using Allen stirrups. The vaginal portion of the procedure included placement of a ZUMI uterine manipulator with a Koh colpotomy ring and a vaginal occluder balloon.,The laparoscopic port sites were anesthetized with intradermal injection of 0.25% Marcaine. There were five ports placed, including a 3-mm left subcostal port, a 10-mm umbilical port, a 10-mm suprapubic port, and 5-mm right and left lower

quadrant ports. The Veress needle was placed through a small incision at the base of the umbilicus, and a pneumoperitoneum was insufflated without difficulty. The 3-mm port was then placed in the left subcostal position without difficulty, and a 3-mm scope was placed. There were no adhesions underlying the previous vertical midline scar. The 10-mm port was placed in the umbilicus, and the laparoscope was inserted. Remaining ports were placed under direct laparoscopic guidance. Washings were obtained from the pelvis, and the abdomen was explored with the laparoscope, with findings as noted.,Attention was then turned to lymphadenectomy. An incision in the retroperitoneum was made over the right common iliac artery, extending up the aorta to the retroperitoneal duodenum. The lymph node bundle was elevated from the aorta and the anterior vena cava until the retroperitoneal duodenum had been reached. Pedicles were sealed and divided with bipolar cutting forceps. Excellent hemostasis was noted. Boundaries of dissection included the ureters laterally, common ileac arteries at uterine crossover inferiorly, and the retroperitoneal duodenum superiorly with careful preservation of the inferior mesenteric artery. Right and left pelvic retroperitoneal spaces were then opened by incising lateral and parallel to the infundibulopelvic ligament with the bipolar cutting forceps. The retroperitoneal space was then opened and the lymph nodes were dissected, with boundaries of dissection being the bifurcation of the common iliac artery superiorly, psoas muscle laterally, inguinal ligament inferiorly, and the anterior division of the

hypogastric artery medially. The posterior boundary was the obturator nerve, which was carefully identified and preserved bilaterally. The left common iliac lymph node was elevated and removed using the same technique.,Attention was then turned to the laparoscopic hysterectomy. The right infundibulopelvic ligament was divided using the bipolar cutting forceps. The mesovarium was skeletonized. A bladder flap was mobilized by dividing the round ligaments using the bipolar cutting forceps, and the peritoneum on the vesicouterine fold was incised to mobilize the bladder. Once the Koh colpotomy ring was skeletonized and in position, the uterine arteries were sealed using the bipolar forceps at the level of the colpotomy ring. The vagina was transected using a monopolar hook (or bipolar spatula), resulting in separation of the uterus and attached tubes and ovaries. The uterus, tubes, and ovaries were then delivered through the vagina, and the pneumo-occluder balloon was reinserted to maintain pneumoperitoneum. The vaginal vault was closed with interrupted figure-of-eight stitches of 0-Vicryl using the Endo-Stitch device. The abdomen was irrigated, and excellent hemostasis was noted.,The insufflation pressure was reduced, and no evidence of bleeding was seen. The suprapubic port was then removed, and the fascia was closed with a Carter-Thomason device and 0-Vicryl suture. The remaining ports were removed under direct laparoscopic guidance, and the pneumoperitoneum was released. The umbilical port was removed using laparoscopic guidance. The umbilical fascia was closed with an interrupted figure-of-eight

stitch using 2-0 Vicryl. The skin was closed with interrupted subcuticular stitches using 4-0 Monocryl suture. The final sponge, needle, and instrument counts were correct at the completion of the procedure. The patient was awakened and taken to the post anesthesia care unit in stable condition.