PREOPERATIVE DIAGNOSES:,1. Chronic pelvic pain.,2. Dysmenorrhea.,3. Dyspareunia.,4. Endometriosis.,5. Enlarged uterus.,6. Menorrhagia.,POSTOPERATIVE DIAGNOSES:,1. Chronic pelvic pain.,2. Dysmenorrhea.,3. Dyspareunia.,4. Endometriosis.,5. Enlarged uterus.,6. Menorrhagia.,PROCEDURE: , Total abdominal hysterectomy and bilateral salpingo-oophorectomy.,ESTIMATED BLOOD LOSS: , Less than 100 mL.,DRAINS: , Foley.,ANESTHESIA:, General.,This 28-year-old white female who presented to undergo TAH-BSO secondary to chronic pelvic pain and a diagnosis of endometriosis.,At the time of the procedure, once entering into the abdominal cavity, there was no gross evidence of abnormalities of the uterus, ovaries or fallopian tube. All endometriosis had been identified laparoscopically from a previous surgery. At the time of the surgery, all the tissue was quite thick and difficult to cut as well around the bladder flap and the uterus itself.,DESCRIPTION OF PROCEDURE: , The patient was taken to the operating room and placed in supine position, at which time general form of anesthesia was administered by the anesthesia department. The patient was then prepped and draped in the usual fashion for a low transverse incision. Approximately two fingerbreadths above the pubic symphysis, a first knife was used to make a low transverse incision. This was extended down to the level of the fascia. The fascia was nicked in the center and extended in a transverse fashion. The edges of the fascia were grasped with Kocher. Both blunt and sharp dissection both caudally and cephalic was then completed

consistent with Pfannenstiel technique. The abdominal rectus muscle was divided in the midline and extended in a vertical fashion. Perineum was entered at the high point and extended in a vertical fashion as well. An O'Connor-O'Sullivan retractor was put in place on either side. A bladder blade was put in place as well. Uterus was grasped with a double-tooth tenaculum and large and small colon were packed away cephalically and held in place with free wet lap packs and a superior blade. The bladder flap was released with Metzenbaum scissors and then dissected away caudally. EndoGIA were placed down both sides of the uterus in two bites on each side with the staples reinforced with a medium Endoclip. Two Heaney were placed on either side of the uterus at the level of cardinal ligaments. These were sharply incised and both pedicles were tied off with 1 Vicryl suture. Two _____ were placed from either side of the uterus at the level just inferior to the cervix across the superior part of the vaginal vault. A long sharp knife was used to transect the uterus at the level of Merz forceps and the uterus and cervix were removed intact. From there, the corners of the vaginal cuff were reinforced with figure-of-eight stitches. Betadine soaked sponge was placed in the vaginal vault and a continuous locking stitch of 0 Vicryl was used to re-approximate the edges with a second layer used to reinforce the first. Bladder flap was created with the use of 3-0 Vicryl and Gelfoam was placed underneath. The EndoGIA was used to transect both the fallopian tube and ovaries at the infundibulopelvic ligament and each one was reinforced with

medium clips. The entire area was then re-peritonized and copious amounts of saline were used to irrigate the pelvic cavity. Once this was completed, Gelfoam was placed into the cul-de-sac and the O'Connor-O'Sullivan retractor was removed as well as all the wet lap pack. Edges of the peritoneum were grasped in 3 quadrants with hemostat and a continuous locking stitch of 2-0 Vicryl was used to re-approximate the peritoneum as well as abdominal rectus muscle. The edges of the fascia were grasped at both corners and a continuous locking stitch of 1 Vicryl was used to re-approximate the fascia with overlapping in the center. The subcutaneous tissue was irrigated. Cautery was used to create adequate hemostasis and 3-0 Vicryl was used to re-approximate the tissue and the skin edges were re-approximated with sterile staples. Sterile dressing was applied and Betadine soaked sponge was removed from the vaginal vault and the vaginal vault was wiped clean of any remaining blood. The patient was taken to recovery room in stable condition. Instrument count, needle count, and sponge counts were all correct.