PREOPERATIVE DIAGNOSES:,1. Vault prolapse.,2. Enterocele.,PREOPERATIVE DIAGNOSES:,1. Vault prolapse.,2. Enterocele.,OPERATIONS:,1. Abdominosacrocolpopexy.,2. Enterocele repair.,3. Cystoscopy.,4. Lysis of adhesions.,ANESTHESIA: , General endotracheal.,ESTIMATED BLOOD LOSS:, Less than 100 mL.,SPECIMEN: , None.,BRIEF HISTORY:, The patient is a 53-year-old female with history of hysterectomy presented with vaginal vault prolapse. The patient had good support in the anterior vagina and in the posterior vagina but had significant apical prolapse. Options such as watchful waiting, pessary, abdominal surgery, robotic sacrocolpopexy versus open sacrocolpopexy were discussed.,The patient already had multiple abdominal scars. Risk of open surgery was little bit higher for the patient. After discussing the options the patient wanted to proceed a Pfannenstiel incision and repair of the sacrocolpopexy. Risks of anesthesia, bleeding, infection, pain, MI, DVT, PE, mesh erogenic exposure, complications with mesh were discussed. The patient understood the risks of recurrence, etc, and wanted to proceed with the procedure. The patient was told to perform no heavy lifting for 3 months, etc. The patient was bowel prepped, preoperative antibiotics were given.,DETAILS OF THE OPERATION: , The patient was brought to the OR, anesthesia was applied. The patient was placed in dorsal lithotomy position. The patient was prepped and draped in usual sterile fashion. A Pfannenstiel low abdominal incision was done at the old incision site. The incision was carried

through the subcutaneous tissue through the fascia and the fascia was lifted off the rectus abdominus muscle. The muscle was split in the middle and peritoneum was entered using sharp mets. There was no injury to the bowel upon entry. There were significant adhesions which were unleashed. All the adhesions in the sigmoid colon from the right lower quadrant and left lower quadrant were released, similarly colon was mobilized. There was minimal space, everything was packed, Bookwalter placed then over the sacral bone. The middle of the sacral bone was identified. The right ureter was clearly identified and was lateral to where the posterior peritoneum was opened. The ligament over the sacral or sacral _____ was easily identified, 0 Ethibond stitches were placed x3. A 1 cm x 5 cm mesh was cut out. This was a Prolene soft mesh which was tied at the sacral ligament. The bladder was clearly off the vault area which was exposed, in the raw surface 0 Ethibond stitches were placed x3. The mesh was attached. The apex was clearly up enterocele sac was closed using 4-0 Vicryl without much difficulty. The ureter was not involved at all in this process. The peritoneum was closed over the mesh. Please note that the peritoneum was opened and it was brought around and over the mesh so that the mesh would not be exposed to the bowel. Prior to closure antibiotic irrigation was done using Ancef solution. The mesh has been exposed in antibiotic solution prior to the usage.,After a through irrigation with L and half of antibiotic solution. All the solution was removed. Good hemostasis was obtained. All the packing was removed. Count was correct.

Rectus abdominus muscle was brought together using 4-0 Vicryl. The fascia was closed using loop #1 PDS in running fascia from both sides and was tied in the middle. Subcutaneous tissue was closed using 4-0 Vicryl and the skin was closed using 4-0 Monocryl in subcuticular fashion. Cystoscopy was done at the end of the procedure. Please note that the Foley was in place throughout the entire procedure which was placed thoroughly at the beginning of the procedure. Cystoscopy was done and indigo carmine has been given. There was good efflux of indigo carmine in both of the ureteral opening. There was no injury to the rectum or the bladder. The bladder appeared completely normal. The rectal exam was done at the end of the procedure after the cystoscopy. After the cysto was done, the scope was withdrawn, Foley was placed back. The patient was brought to recovery in the stable condition.