PREOPERATIVE DIAGNOSIS:, Pelvic pain.,POSTOPERATIVE DIAGNOSES:,1. Pelvic pain.,2. Pelvic endometriosis.,3. Pelvic adhesions.,PROCEDURE PERFORMED:,1. Laparoscopy.,2. Harmonic scalpel ablation of endometriosis.,3. Lysis of adhesions.,4. Cervical dilation.,ANESTHESIA: ,General.,SPECIMEN: ,Peritoneal biopsy.,ESTIMATED BLOOD LOSS:, Scant.,COMPLICATIONS: , None.,FINDINGS: , On bimanual exam, the patient has a small, anteverted, and freely mobile uterus with no adnexal masses. Laparoscopically, the patient has large omental to anterior abdominal wall adhesions along the left side of the abdomen extending down to the left adnexa. There are adhesions involving the right ovary to the anterior abdominal wall and the bowel. There are also adhesions from the omentum to the anterior abdominal wall near the liver. The uterus and ovaries appear within normal limits other than the adhesions. The left fallopian tube grossly appeared within normal limits. The right fallopian tube was not well visualized but appeared grossly scarred and no tubal end was visualized. There was a large area of endometriosis, approximately 1 cm wide in the left ovarian fossa and there was a small spot of endometriosis in the posterior cul-de-sac. There was also vesicular appearing endometriosis lesion in the posterior cul-de-sac.,PROCEDURE: ,The patient was taken in the operating room and generalized anesthetic was administered. She was then positioned in the dorsal lithotomy position and prepped and draped in the normal sterile fashion. After exam under anesthetic, weighted speculum was placed

in the vagina. The anterior lip of the cervix was grasped with vulsellum tenaculum. The uterus was sounded and then was serially dilated with Hank dilators to a size 10 Hank, then the uterine manipulator was inserted and attached to the anterior lip of the cervix. At this point, the vulsellum tenaculum was removed along with the weighted speculum and attention was turned towards the abdomen. An approximately 2 cm incision was made immediately inferior to the umbilicus with the skin knife. The superior aspect of the umbilicus was grasped with a towel clamp. The abdomen was tented up and a Veress needle inserted through this incision. When the Veress needle was felt to be in place, deep position was checked by placing saline in the needle. This was seen to freely drop in the abdomen so it was connected to CO2 gas. Again, this was started at the lowest setting, was seen to flow freely, so it was advanced to the high setting. The abdomen was then insufflated to an adequate distention. Once an adequate distention was reached, the CO2 gas was disconnected. The Veress needle was removed and a size #11 step trocar was placed. Next, the laparoscope was inserted through this port. The medial port was connected to CO2 gas. Next, a 1 cm incision was made in the midline approximately 2 fingerbreadths above the pubic symphysis. Through this, a Veress needle was inserted followed by size #5 step trocar and this procedure was repeated under direct visualization on the right upper quadrant lateral to the umbilicus and a size #5 trocar was also placed. Next, a grasper was placed through the suprapubic port. This was used to grasp the bowel that

was adhesed to the right ovary and the Harmonic scalpel was then used to lyse these adhesions. Bowel was carefully examined afterwards and no injuries or bleeding were seen. Next, the adhesions touching the right ovary and anterior abdominal wall were lysed with the Harmonic scalpel and this was done without difficulty. There was a small amount of bleeding from the anterior abdominal wall peritoneum. This was ablated with the Harmonic scalpel. The Harmonic scalpel was used to lyse and ablate the endometriosis in the left ovarian fossa and the posterior cul-de-sac. Both of these areas were seen to be hemostatic. Next, a grasper was placed and was used to bluntly remove the vesicular lesion from the posterior cul-de-sac. This was sent to pathology. Next, the pelvis was copiously irrigated with the Nezhat dorsi suction irrigator and the irrigator was removed. It was seen to be completely hemostatic. Next, the two size #5 ports were removed under direct visualization. The camera was removed. The abdomen was desufflated. The size #11 introducer was replaced and the #11 port was removed.,Next, all the ports were closed with #4-0 undyed Vicryl in a subcuticular interrupted fashion. The incisions were dressed with Steri-Strips and bandaged appropriately and the patient was taken to recovery in stable condition and she will be discharged home today with Darvocet for pain and she will follow-up in one week in the clinic for pathology results and to have a postoperative check.