PREOPERATIVE DIAGNOSIS: , Large left adnexal mass, 8 cm in diameter.,POSTOPERATIVE DIAGNOSIS: , Pelvic adhesions, 6 cm ovarian cyst.,PROCEDURES PERFORMED: ,1. Pelvic laparotomy.,2. Lysis of pelvic adhesions.,3. Left salpingooophorectomy with insertion of Pain-Buster Pain Management System by Dr. X.,GROSS FINDINGS: ,There was a transabdominal mass palpable in the lower left quadrant. An ultrasound suggestive with a mass of 8 cm, did not respond to suppression with norethindrone acetate and on repeat ultrasound following the medical treatment, the ovarian neoplasm persisted and did not decreased in size.,PROCEDURE: ,Under general anesthesia, the patient was placed in lithotomy position, prepped and draped. A low transverse incision was made down to and through to the rectus sheath. The rectus sheath was put laterally. The inferior epigastric arteries were identified bilaterally, doubly clamped and tied with #0 Vicryl sutures. The rectus muscle was then split transversally and the peritoneum was split transversally as well. The left adnexal mass was identified and large bowel was attached to the mass and Dr. Zuba from General Surgery dissected the large bowel adhesions and separated them from the adnexal mass. The ureter was then traced and found to be free of the mass and free of the infundibulopelvic ligament. The infundibulopelvic ligament was isolated, entered via blunt dissection. A #0 Vicryl suture was put into place, doubly clamped with curved Heaney clamps, cut with curved Mayo scissors and #0 Vicryl fixation suture put into place. Curved Heaney clamps were then used

to remove the remaining portion of the ovary from its attachment to the uterus and then #0 Vicryl suture was put into place. Pathology was called to evaluate the mass for potential malignancy and the pathology's verbal report at the time of surgery was that this was a benign lesion. Irrigation was used. Minimal blood loss at the time of surgery was noted. Sigmoid colon was inspected in place in physiologic position of the cul-de-sac as well as small bowel omentum. Instrument, needle, and sponge counts were called for and found to be correct. The peritoneum was closed with #0 Vicryl continuous running locking suture. The rectus sheath was closed with #0 Vicryl continuous running locking suture. A DonJoy Pain-Buster Pain Management System was placed through the skin into the subcutaneous space and the skin was closed with staples. Final instrument needle counts were called for and found to be correct. The patient tolerated the procedure well with minimal blood loss and transferred to recovery area in satisfactory condition.