PREOPERATIVE DIAGNOSES:,1. Enlarged fibroid uterus.,2. Abnormal uterine bleeding.,POSTOPERATIVE DIAGNOSES:,1. Enlarged fibroid uterus.,2. Abnormal uterine bleeding.,PROCEDURE PERFORMED: , Total abdominal hysterectomy with a uterosacral vault suspension.,ANESTHESIA: , General with endotracheal tube as well as spinal with Astramorph.,ESTIMATED BLOOD LOSS: , 150 cc.,URINE OUTPUT: ,250 cc of clear urine at the end of the procedure.,FLUIDS:, 2000 cc of crystalloids.,COMPLICATIONS: , None.,TUBES: , None.,DRAINS: ,Foley to gravity.,PATHOLOGY: , Uterus, cervix, and multiple fibroids were sent to pathology for review.,FINDINGS: ,On exam, under anesthesia, normal appearing vulva and vagina, a massively enlarged uterus approximately 20 weeks' in size with irregular contours suggestive of fibroids.,Operative findings demonstrated a large fibroid uterus with multiple subserosal and intramural fibroids as well as there were some filmy adnexal adhesions bilaterally. The appendix was normal appearing. The bowel and omentum were normal appearing. There was no evidence of endometriosis. Peritoneal surfaces and vesicouterine peritoneum as well as appendix and cul-de-sac were all free of any evidence of endometriosis.,PROCEDURE:, After informed consent was obtained and all questions were answered to the patient's satisfaction in layman's terms, she was taken to the Operating Room where first a spinal anesthesia with Astramorph was obtained without any difficulty. She then underwent a general anesthesia with

endotracheal tube also without any difficulty. She was then examined under anesthesia with noted findings as above. The patient was then placed in dorsal supine position and prepped and draped in the usual sterile fashion.. A vertical skin incision was made 1 cm below the umbilicus extending down to 2 cm above the pubic symphysis. This was made with a first knife and then carried down to the underlying layer of the fascia with the second knife. Fascia was excised in the midline and extended superiorly and inferiorly with the Mayo scissors. The rectus muscle was then separated in the midline. The peritoneum identified and entered bluntly. The peritoneal incision was then extended superiorly and inferiorly with external visualization of the bladder. The uterus was markedly evident upon entering the peritoneal cavity. The uterus was then exteriorized and noted to have the findings as above. At this point, approximately 10 cc of vasopressin 20 units and 30 cc was injected into the uterine fundus and multiple fibroids were removed by using the incision with the Bovie and then using a blunt and the sharp dissection and grasping with Lahey clamps. Once the debulking of the uterus was felt appropriate to proceed with the hysterectomy, the uterus was then reapproximated with a few #0 Vicryl sutures in a figure-of-eight fashion. The round ligaments were identified bilaterally and clamped with the hemostats and transacted with the Metzenbaum scissors. The round ligaments were then bilaterally tied with the #0 tie and noted to be hemostatic. The uterovarian vessels bilaterally were then isolated through a vascular window created from taking down the round

ligaments. The uterovarian vessels bilaterally were #0 tied and then doubly clamped with straight Ochsner clamps and transacted and suture tied with a Heaney hand stitch fashion, and both uterine and ovarian vessels were noted to be hemostatic. At this time, the attention was then turned to the vesicouterine peritoneum, which was tented up with Allis clamps and the bladder flap was then created sharply with Russian pickups and the Metzenbaum scissors. Then the bladder was bluntly dissected off the underlying cervix with a moist Ray-Tec sponge down to the level of the cervix.,At this point, the uterus was pulled on traction and the uterosacral ligaments were easily visualized. Using #2-0 PDS suture, the suture was placed through both uterosacral ligaments distally with a backhand stitch fashion throwing the sutures from lateral to medial. These sutures were then tagged and saved for later. The uterine vessels were then identified bilaterally and skeletonized, then clamped with straight Ochsner clamps balancing off the cervix, and the uterine vessels were then transacted and suture ligated with #0 Vicryl and noted to be hemostatic. In a similar fashion, the broad ligament down to the level of the cardinal ligaments was clamped with curved Ochsner and transacted and suture ligated and noted to be hemostatic. At this point, the Lahey clamp was placed on the cervix and the cervix was tented up. The pubocervical vesical fascia was transacted with long knife. Then while protecting posteriorly, using the double-pointed scissors, the vagina was entered with double-pointed scissors at the level of the cervix and was grasped with a straight Ochsner clamp. The uterus

and cervix were then amputated using the Jorgenson scissors and the cuff was outlined with Ochsner clamps. The cuff was then copiously painted with Betadine soaked sponge. The Betadine-soaked sponge was placed in the patient's vagina. Then the cuff was then closed with a #0 Vicryl in a running locked fashion to make sure to bring the ipsilateral cardinal ligaments into the vaginal cuff. This was accomplished with one #0 Vicryl running stitch and then an Allis clamp was placed in the midsection portion of the cuff and tented up and a #0 Vicryl figure-of-eight was placed in the midsection portion of the cuff. At this time, the uterosacral ligaments previously tagged needle was brought through the cardinal ligament and the uterosacral ligament on the ipsilateral side. The needle was cut off and these were then tagged with the hemostats. The cuff was then closed by taking the running suture and bringing back through the posterior peritoneum, grabbing part of the uterosacral and midsection portion of the posterior peritoneum of the uterosacral and then tying the cuff down to bunch and cuff together. The suture in the midportion of the cuff was then used to tie down the round ligaments bilaterally to the cuff. The abdomen was copiously irrigated with warm normal saline. All areas were noted to be hemostatic. Then the previously tagged uterosacral sutures were then tied bringing the vaginal cuff angles down to the uterosacral ligaments. The abdomen was then once again copiously irrigated with warm normal saline. All areas were noted to be hemostatic. The sigmoid colon was replaced back into the hollow of the sacrum. Then the omentum was pulled over the

bowel. After the myomectomy was performed, the GYN Balfour was placed into the patient's abdomen and the bowel was packed away with moist laparotomy sponges. The GYN Balfour was then removed. Packing sponges were removed and the fascia was then closed in an interrupted figure-of-eight fashion with #0 Vicryl.,Skin was closed with staples. The patient tolerated the procedure well. The sponge, lap, and needle counts were correct x2. The sponge from the patient's vagina was removed and the vagina was noted to be hemostatic. The patient would be followed throughout her hospital stay.