PREOPERATIVE DIAGNOSIS: , Endometrial cancer.,POSTOPERATIVE DIAGNOSIS: , Same.,OPERATION PERFORMED:, Exploratory laparotomy, total abdominal hysterectomy, bilateral salpingo-oophorectomy, right and left pelvic lymphadenectomy, common iliac lymphadenectomy, and endometrial cancer staging procedure.,ANESTHESIA:, General, endotracheal tube.,SPECIMENS: , Pelvic washings for cytology, uterus with attached tubes and ovaries, right and left pelvic lymph nodes, para-aortic nodes.,INDICATIONS FOR PROCEDURE: , The patient recently presented with postmenopausal bleeding and was found to have a Grade II endometrial carcinoma on biopsy. She was counseled to undergo staging laparotomy.,FINDINGS:, Examination under anesthesia revealed a small uterus with no nodularity. During the laparotomy, the uterus was small, mobile, and did not show any evidence of extrauterine spread of disease. Other abdominal viscera, including the diaphragm, liver, spleen, omentum, small and large bowel, and peritoneal surfaces, were palpably normal. There was no evidence of residual neoplasm after removal of the uterus. The uterus itself showed no serosal abnormalities and the tubes and ovaries were unremarkable in appearance.,PROCEDURE: , The patient was brought to the Operating Room with an IV in place. Anesthesia was induced, after which she was examined, prepped and draped.,A vertical midline incision was made and fascia was divided. The peritoneum was entered without difficulty and washings were obtained. The

abdomen was explored with findings as noted. A Bookwalter retractor was placed and bowel was packed. Clamps were placed on the broad ligament for traction. The retroperitoneal spaces were opened by incising lateral and parallel to the infundibulopelvic ligament. The round ligaments were isolated, divided, and ligated. The peritoneum overlying the vesicouterine fold was incised to mobilize the bladder.,Retroperitoneal spaces were then opened, allowing exposure of pelvic vessels and ureters. The infundibulopelvic ligaments were isolated, divided, and doubly ligated. The uterine artery pedicles were skeletonized, clamped, divided, and suture ligated. Additional pedicles were developed on each side of the cervix, after which tissue was divided and suture ligated. When the base of the cervix was reached, the vagina was cross-clamped and divided, allowing removal of the uterus with attached tubes and ovaries. Angle stitches of o-Vicryl were placed, incorporating the uterosacral ligaments and the vaginal vault was closed with interrupted figure-of-eight stitches. The pelvis was irrigated and excellent hemostasis was noted.,Retractors were repositioned to allow exposure for lymphadenectomy. Metzenbaum scissors were used to incise lymphatic tissues. Borders of the pelvic node dissection included the common iliac bifurcation superiorly, the psoas muscle laterally, the cross-over of the deep circumflex iliac vein over the external iliac artery inferiorly, and the anterior division of the hypogastric artery medially. The posterior border of dissection was the obturator nerve, which was carefully identified and preserved bilaterally. Ligaclips

were applied where necessary. After the lymphadenectomy was performed bilaterally, excellent hemostasis was noted.,Retractors were again repositioned to allow exposure of para-aortic nodes. Lymph node tissue was mobilized, Ligaclips were applied, and the tissue was excised. The pelvis was again irrigated and excellent hemostasis was noted. The bowel was run and no evidence of disease was seen.,All packs and retractors were removed and the abdominal wall was closed using a running Smead-Jones closure with #1 permanent monofilament suture. Subcutaneous tissues were irrigated and a Jackson-Pratt drain was placed. Scarpa's fascia was closed with a running stitch and skin was closed with a running subcuticular stitch. The final sponge, needle and instrument counts were correct at the completion of the procedure. ,The patient was then awakened from her anesthetic and taken to the Post Anesthesia Care Unit in stable condition.