PREOPERATIVE DIAGNOSIS:, Left adnexal mass.,POSTOPERATIVE DIAGNOSIS:, Left ovarian lesion.,PROCEDURE PERFORMED: ,Laparoscopy with left salpingo-oophorectomy.,ANESTHESIA:, General.,ESTIMATED BLOOD LOSS: , Less than 50 cc.,COMPLICATIONS:, None.,FINDINGS:, The labia and perineum were within normal limits. The hymen was found to be intact. Laparoscopic findings revealed a 4 cm left adnexal mass, which appeared fluid filled. There were a few calcifications on the surface of the mass. The right ovary and fallopian tube appeared normal. There was no evidence of endometriosis. The uterus appeared normal in size. There were no pelvic adhesions noted.,INDICATIONS: , The patient is a 55-year-old gravida 0, para 0 Caucasian female who presents with a left adnexal mass on ultrasound which is 5.3 cm. She does complain of minimal discomfort. Bimanual exam was not able to be performed secondary to the vaginal stenosis and completely intact hymen.,PROCEDURE IN DETAIL: , After informed consent was obtained, the patient was taken back to the Operative Suite, prepped and draped, and placed in the dorsal lithotomy position. A 1 cm skin incision was made in the infraumbilical vault. While tenting up the abdominal wall, the Veress needle was inserted without difficulty and the abdomen was insufflated. This was done using appropriate flow and volume of CO2. The #11 step trocar was then placed without difficulty. The above findings were confirmed. A #12 mm port was then placed approximately 2 cm above the pubic symphysis under direct

visualization. Two additional ports were placed, one on the left lateral aspect of the abdominal wall and one on the right lateral aspect of the abdominal wall. Both #12 step ports were done under direct visualization. Using a grasper, the mass was tented up at the inferior pelvic ligament and the LigaSure was placed across this and several bites were taken with good visualization while ligating. The left ovary was then placed in an Endocatch bag and removed through the suprapubic incision. The skin was extended around this incision and the fascia was extended using the Mayo scissors. The specimen was removed intact in the Endocatch bag through this site. Prior to desufflation of the abdomen, the site where the left adnexa was removed was visualized to be hemostatic. All the port sites were hemostatic as well. The fascia of the suprapubic incision was then repaired using a running #0 Vicryl stitch on a UR6 needle. The skin was then closed with #4-0 undyed Vicryl in a subcuticular fashion. The remaining incisions were also closed with #4-0 undyed Vicryl in a running fashion after all instruments were removed and the abdomen was completely desufflated. Steri-Strips were placed on each of the incisions. The patient tolerated the procedure well. Sponge, lap, and needle count were x2. She will go home on Vicodin for pain and followup postoperatively in the office where we will review path report with her.