PREOPERATIVE DIAGNOSES:,1. Cervical intraepithelial neoplasia grade-III status post conization with poor margins.,2. Recurrent dysplasia.,3. Unable to follow in office.,4. Uterine procidentia grade II-III.,POSTOPERATIVE DIAGNOSES:,1. Cervical intraepithelial neoplasia grade-III postconization.,2. Poor margins.,3. Recurrent dysplasia.,4. Uterine procidentia grade II-III.,5. Mild vaginal vault prolapse.,PROCEDURES PERFORMED:,1. Total abdominal hysterectomy (TAH) with bilateral salpingooophorectomy.,2. Uterosacral ligament vault suspension.,ANESTHESIA: , General and spinal with Astramorph for postoperative pain.,ESTIMATED BLOOD LOSS: , Less than 100 cc.,FLUIDS: ,2400 cc.,URINE: , 200 cc of clear urine output.,INDICATIONS: ,This patient is a 57-year-old nulliparous female who desires definitive hysterectomy for history of cervical intraepithelial neoplasia after conization and found to have poor margins.,FINDINGS: ,On bimanual examination, the uterus was found to be small. There were no adnexal masses appreciated. Intraabdominal findings revealed a small uterus approximately 2 cm in size. The ovaries were atrophic consistent with menopause. The liver margins and stomach were palpated and found to be normal.,PROCEDURE IN DETAIL: , After informed consent was obtained, the patient was taken back to the operating suite and administered a spinal anesthesia for postoperative pain control. She was then placed in the dorsal lithotomy position and administered general anesthesia. She was then prepped and draped in the sterile fashion and an indwelling

Foley catheter was placed in her bladder. At this point, the patient was evaluated for a possible vaginal hysterectomy. She was nulliparous and the pelvis was narrow. After the anesthesia was administered, the patient was repeatedly stooling and therefore because of these two reasons, the decision was made to do an abdominal hysterectomy. After the patient was prepped and draped, a Pfannenstiel skin incision was made approximately 2 cm above the pubic symphysis. The second scalpel was used to dissect out to the underlying layer of fascia. The fascia was incised in the midline and extended laterally using the Mayo scissors. The superior aspect of the rectus fascia was grasped with Ochsners, tented up and underlying layer of rectus muscle was dissected off bluntly as well as with Mayo scissors. In a similar fashion, the inferior portion of the rectus fascia was tented up, dissected off bluntly as well as with Mayo scissors. The rectus muscle was then separated bluntly in the midline and the peritoneum was identified and entered with the Metzenbaum. The peritoneal incision was extended superiorly and inferiorly with good visualization of the bladder. At this point, the above findings were noted and the GYN Balfour retractor was placed. Moist laparotomy sponges were used to pack the bowel out of the operative field. The bladder blade and the extension for the retractor were then placed. An Allis was used on the uterus for retraction. The round ligaments were then identified, clamped with two hemostats and transected and then suture ligated. The anterior portion of the broad ligament was dissected along vesicouterine resection.

The bladder was then dissected off the anterior cervix and vagina without difficulty. The infundibulopelvic ligaments on both sides were then doubly clamped using hemostats, transected and suture ligated with #0 Vicryl suture. The uterine vessels on both sides were skeletonized and clamped with two hemostats and transected and suture ligated with #0 Vicryl. Good hemostasis was assured. The cardinal ligaments on both sides were clamped using a curved hemostat, transected and suture ligated with #0 Vicryl. Good hemostasis was obtained. Two hemostats were then placed just under the cervix meeting in the midline. The uterus and cervix were then _____ off using a scalpel. This was handed and sent to Pathology for evaluation. Using #0 Vicryl suture, the right vaginal cuff angle was closed and affixed to the ipsilateral cardinal ligament. A baseball stitch was then used to close the cuff to the midline. The same was done to the left vaginal cuff angle, which was affixed to the ipsilateral and cardinal ligaments. The baseball stitch was used to close the cuff to the midline. The hemostats were removed and the cuff was closed and good hemostasis was noted. The uterosacral ligaments were also transfixed to the cuff and brought out for good support by using a #0 Vicryl suture through each uterosacral ligament and incorporating this into the vaginal cuff. The pelvis was then copiously irrigated with warm normal saline. Good support and hemostasis was noted. The bowel packing was then removed and the GYN Balfour retractor was moved. The peritoneum was then repaired with #0 Vicryl in a running fashion. The fascia was then closed using #0 Vicryl in

a running fashion, marking the first stitch and first last stitch in a lateral to medial fashion. The skin was then closed with #4-0 undyed Vicryl in a subcuticular closure and an Op-Site was placed over this. The patient was then brought out of general anesthesia and extubated. The patient tolerated the procedure well. Sponge, lap, and needle counts were correct x2. She will follow up postoperatively as an inpatient.