PREOPERATIVE DIAGNOSIS:, Sterilization candidate.,POSTOPERATIVE DIAGNOSIS:, Sterilization candidate.,PROCEDURE PERFORMED:,1. Cervical dilatation.,2. Laparoscopic bilateral partial salpingectomy.,ANESTHESIA: , General endotracheal.,COMPLICATIONS: , None.,ESTIMATED BLOOD LOSS: ,Less than 50 cc.,SPECIMEN: , Portions of bilateral fallopian tubes.,INDICATIONS:, This is a 30-year-old female gravida 4, para-3-0-1-3 who desires permanent sterilization.,FINDINGS: , On bimanual exam, the uterus is small, anteverted, and freely mobile. There are no adnexal masses appreciated. On laparoscopic exam, the uterus, bilateral tubes and ovaries appeared normal. The liver margin and bowel appeared normal.,PROCEDURE: , After consent was obtained, the patient was taken to the operating room where general anesthetic was administered. The patient was placed in dorsal lithotomy position and prepped and draped in the normal sterile fashion. A sterile speculum was placed in the patient's vagina and the anterior lip of the cervix was grasped with a vulsellum tenaculum. The uterus was then sounded to 7 cm.,The cervix was serially dilated with Hank dilators. A #20 Hank dilator was left in place. The sterile speculum was then removed. Gloves were changed. Attention was then turned to the abdomen where approximately a 10 mm transverse infraumbilical incision was made through the patient's previous scar. The Veress needle was placed and gas was turned on. When good flow and low abdominal pressures were noted, the gas was turned up and the

abdomen was allowed to insufflate. A 11 mm trocar was then placed through this incision and the camera was placed with the above findings noted. Two 5 mm step trocars were placed, one 2 cm superior to the pubic bone along the midline and the other approximately 7 cm to 8 cm to the left at the level of the umbilicus. The Endoloop was placed through the left-sided port. A grasper was placed in the suprapubic port and put through the Endoloop and then a portion of the left tube was identified and grasped with a grasper. A knuckle of tube was brought up with the grasper and a #0 Vicryl Endoloop synched down across this knuckle of tube. The suture was then cut using the endoscopic shears. The portion of tube that was tied off was removed using a Harmonic scalpel. This was then removed from the abdomen and sent to Pathology. The right tube was then identified and in a similar fashion, the grasper was placed through the loop of the #0 Vicryl Endoloop and the right tube was grasped with the grasper and the knuckle of tube was brought up into the loop. The loop was then synched down. The Endoshears were used to cut the suture. The Harmonic scalpel was then used to remove that portion of tube. The portion of the tube that was removed from the abdomen was sent to Pathology. Both tubes were examined and found to have excellent hemostasis. All instruments were then removed. The 5 mm ports were removed with good hemostasis noted. The camera was removed and the abdomen was allowed to desufflate. The 11 mm trocar introducer was replaced and the trocar was removed. The fascia of the infraumbilical incision was reapproximated with

an interrupted suture of #3-0 Vicryl. The skin was then closed with #4-0 undyed Vicryl in a subcuticular fashion. Approximately 10 cc of Marcaine was injected at the incision site. The vulsellum tenaculum and cervical dilator were then removed from the patient's cervix with excellent hemostasis noted. The patient tolerated the procedure well. Sponge, lap, and needle counts were correct at the end of the procedure. The patient was taken to the recovery room in satisfactory condition. She will be discharged home with a prescription for Vicodin for pain and was instructed to follow up in the office in two weeks.