PREOPERATIVE DIAGNOSES:,1. Chronic pelvic pain.,2. Hypermenorrhea.,3. Desire for future fertility.,4. Failed conservative medical therapy.,POSTOPERATIVE DIAGNOSES:,1. Chronic pelvic pain.,2. Hypermenorrhea.,3. Desire for future fertility.,4. Failed conservative medical therapy.,5. Possible adenomyosis.,6. Left hydrosalpinx.,7. Suspicion for endometriosis.,PROCEDURES PERFORMED:,1. Dilation and curettage (D&C;).,2. Laparoscopy.,3. Harmonic scalpel ablation of lesion which is suspicious for endometriosis.,ANESTHESIA: , General with endotracheal tube.,ESTIMATED BLOOD LOSS: , Less than 20 cc.,COMPLICATIONS:, None.,INDICATIONS: , This is a 35-year-old Caucasian female gravida 1, para 0-0-1-0 with a history of spontaneous abortion. This patient had approximately greater than ten years of chronic pelvic pain with dysmenorrhea which has significantly affected her activities of daily living. Symptoms have not improved with prescription of oral contraceptives.,The patient has had one prior surgery for a left ovarian cystectomy done by laparoscopy in 1996. The cyst was not diagnosed as an endometrioma. The patient does desire future fertility; however, would like a definitive diagnosis. Conservative medical therapy was offered i.e. Lupron or repeat oral contraceptives, but declined.,FINDINGS:, Bimanual exam reveals a small retroverted uterus which is easily mobile. There were no adnexal masses. The cervix was normal on palpation. A fibrotic band was noted at the internal os during dilation. On laparoscopic exam, the uterus was found to be

small with mild spongy texture. On palpation, the right ovary and adnexa were grossly normal with no evidence of endometriosis. The left ovary was grossly normal. The left fallopian tube had a mild hydrosalpinx present. The left uterosacral ligament had three to four 1 mm to 2 mm lesions that were vesicular in nature consistent with endometriosis. The vesicouterine reflection in the anterior aspect of the uterus were within normal limits as were the posterior cul-de-sac. The liver appeared grossly normal. There were no obvious pelvic adhesions. The left internal inguinal ring is somewhat patent, however, there is no bowel or viscera protruding through it.,PROCEDURE: ,The patient was seen in the preop suite. History was reviewed and all questions were answered. The patient was then taken to the operative suite where she was placed under general anesthesia with endotracheal tube. She was placed in a dorsal lithotomy position in Allen stirrups. She was prepped and draped in the normal sterile fashion. Her bladder was drained with a red Robinson catheter producing approximately 100 cc of clear yellow urine. A bimanual exam was performed by Dr. X, Dr. Y, and Dr. Z with above findings noted. A sterile weighted speculum was placed in posterior aspect of the vagina and the anterior aspect of the cervix was grasped with vulsellum tenaculum. There was an attempt to place the uterine sound through the external and internal cervical os, however, secondary to a fibrotic band at the internal os that was impossible. A #9 dilator was allowed to remain in the cervix for minimal manipulation while attention was then turned to the

abdomen. An infraumbilical incision was made using skin scalpel. The Veress needle was placed and CO2 was insufflated. It was immediately noticed that the pressures were inconsistent with intraabdominal insufflation and the CO2 was discontinued and Veress needle was completely removed. A second attempt placement of the Veress needle into the abdomen was successful and CO2 was insufflated approximately 3 liters with minimal intraabdominal pressure. The #12 port was placed and the laparoscope was inserted. Attention was then turned back to the uterus and with the assistance of current hemostat to bluntly dissect the fibrotic band of the internal os.,Successful sounding of the uterus showed an 8-cm uterus that was in a retroverted position. The cervix was serially dilated using Hank dilators to allow for introduction of the sharp curette. A curettage was then performed and specimen of the endometrium was sent for pathologic evaluation. This procedure was performed under direct laparoscopic visualization. Laparoscopic evaluation of the pelvis was performed and the above findings noted. A second abdominal incision was performed suprapubically using a skin scalpel and the Veress needle was placed through the incision successfully under direct visualization. A #5 port was then placed through the sheath and the uterine manipulator was used to complete visualization. The manipulator was then removed and the Harmonic scalpel was placed through the #5 port. The Harmonic scalpel was used then to ablate the 1 mm vesicular lesions on the left uterosacral ligament. The lesions were suspect for

endometriosis, however, they were not diagnostic of endometriosis. There was also present a 3 mm to 5 mm submucosal uterine fibroid on the right lower uterine segment. The Harmonic scalpel was removed from the abdomen as was the #5 port. The incision was internally found to be hemostatic. The laparoscope was then removed from the abdomen. The abdomen was desufflated. The introducer was then replaced into the #12 port and the #12 port was removed from the abdomen. The uterine manipulator was removed from the uterus and the cervix was found to be hemostatic. The weighted speculum was then removed. The patient taken out of dorsal lithotomy position. She was recovered from general anesthesia and taken to the postoperative suite for complete recovery. The patient's discharge instructions will include a followup in one to two weeks in Dr. X's office for discussion of pathology. Her family was notified of the findings. She will be instructed not to have intercourse or use tampons or douche for the next two weeks. The patient will be sent home with a prescription for Darvocet for pain.