PREOPERATIVE DIAGNOSIS: , Chronic pelvic pain, probably secondary to endometriosis.,POSTOPERATIVE DIAGNOSIS:, Mild pelvic endometriosis.,PROCEDURE:,1. Attempted laparoscopy.,2. Open laparoscopy.,3. Fulguration of endometrial implant.,ANESTHESIA: , General endotracheal.,BLOOD LOSS: , Minimal.,COMPLICATIONS: , None.,INDICATIONS: ,The patient is a 21-year-old single female with chronic recurrent pelvic pain unresponsive to both estrogen and progesterone-containing birth control pills, either cyclically or daily as well as progestational medication only, who had a negative GI workup recently including colonoscopy, and desired definitive operative evaluation and diagnosis prior to initiation of a 6-month course of Depo-Lupron.,PROCEDURE: , After an adequate plane of general anesthesia had been obtained, the patient was placed in a dorsal lithotomy position. She was prepped and draped in the usual sterile fashion for pelviolabdominal surgery. Bimanual examination revealed a mid position normal-sized uterus with benign adnexal area.,In the high lithotomy position, a weighted speculum was placed into the posterior vaginal wall. The anterior lip of the cervix was grasped with a single-tooth tenaculum. A Hulka tenaculum was placed transcervically. The other instruments were removed. A Foley catheter was placed transurethrally to drain the bladder intraoperatively.,In the low lithotomy position and in steep Trendelenburg, attention was turned to the infraumbilical region. Here, a stab wound incision was made through which the 120 mm Veress needle was placed and approximately 3 L

of carbon dioxide used to create a pneumoperitoneum. The needle was removed, the incision minimally enlarged, and the #5 trocar and cannula were placed. The trocar was removed and the scope placed confirming a preperitoneal insufflation.,The space was drained off the insufflated gas and 2 more attempts were made, which failed due to the patient's adiposity. Attention was turned back to the vaginal area where in the high lithotomy position, attempts were made at a posterior vaginal apical insertion. The Hulka tenaculum was removed, the posterior lip of the cervix grasped with a single-tooth tenaculum, and the long Allis clamp used to grasp the posterior fornix on which was placed traction. The first short and subsequently 15 cm Veress needles were attempted to be placed, but after several passes, no good pneumoperitoneum could be established via this route also. It was elected not to do a transcervical intentional uterine perforation, but to return to the umbilical area. The 15 cm Veress needle was inserted several times, but again a pneumo was preperitoneal.,Finally, an open laparoscopic approach was undertaken. The skin incision was expanded with a knife blade. Blunt dissection was used to carry the dissection down to the fascia. This was grasped with Kocher clamps, entered sharply and opened transversely. Four 0 Vicryl sutures were placed as stay sutures and tagged with hemostats and needles were cutoff. Dissection continued between the rectus muscle and finally the anterior peritoneum was reached, grasped, elevated, and entered.,At this juncture, the Hasson cannula was placed and tied snugly with the

above stay sutures while the pneumoperitoneum was being created, a #10 scope was placed confirming the intraperitoneal positioning.,Under direct visualization, a suprapubic 5 mm cannula and manipulative probe were placed. Clockwise inspection of the pelvis revealed a benign vesicouterine pouch, normal uterus and fundus, normal right tube and ovary. In the cul-de-sac, there were 3 clusters of 3 to 5 carbon charred type endometrial implants and those more distally in the greatest depth had created puckering and tenting. The left tube and ovary were normal. There were no adhesions. There was no evidence of acute pelvic inflammatory disease.,The Endoshears and subsequently cautery on a hook were placed and the implants fulgurated. Pictures were taken for confirmation both before and after the burn.,The carbon chars were irrigated and aspirated. The smoke plume was removed without difficulty. Approximately 50 mL of irrigant was left in the pelvis. Due to the difficulty in placing and maintaining the Hasson cannula, no attempts were made to view the upper abdominal quadrant, specifically the liver and gallbladder.,The suprapubic cannula was removed under direct visualization, the pneumo released, the scope removed, the stay sutures cut, and the Hasson cannula removed. The residual sutures were then tied together to completely occlude the fascial opening so that there will be no future hernia at this site. Finally, the skin incisions were approximated with 3-0 Dexon subcuticularly. They had been preincisionally injected with bupivacaine to which the patient said she had no known allergies. The vaginal instruments

were removed. All counts were correct. The patient tolerated the procedure well and was taken to the recovery room in stable condition.