PREOPERATIVE DIAGNOSIS,1. Dysmenorrhea.,2. Menorrhagia.,POSTOPERATIVE DIAGNOSIS,1. Dysmenorrhea.,2. Menorrhagia.,PROCEDURE:, Laparoscopic supracervical hysterectomy.,ESTIMATED BLOOD LOSS:, 30 cc.,COMPLICATIONS:, None.,INDICATIONS FOR SURGERY: , A female with a history of severe dysmenorrhea and menorrhagia unimproved with medical management. Please see clinic notes. Risks of bleeding, infection, damage to other organs have been explained. Informed consent was obtained.,OPERATIVE FINDINGS:, Slightly enlarged but otherwise normal-appearing uterus. Normal-appearing adnexa bilaterally.,OPERATIVE PROCEDURE IN DETAIL: , After administration of general anesthesia the patient was placed in dorsal lithotomy position, prepped and draped in the usual sterile fashion. Uterine manipulator was inserted as well as a Foley catheter and this was then draped off from the remainder of the abdominal field. A 5 mm incision was made umbilically after injecting 0.25% Marcaine; 0.25% Marcaine was injected in all the incisional sites. Veress needle was inserted, position confirmed using the saline drop method. After confirming an opening pressure of 4 mmHg of CO2 gas, approximately four liters was insufflated in the abdominal cavity. Veress needle was removed and a 5 mm port placed and position confirmed using the laparoscope. A 5 mm port was placed three fingerbreadths suprapubically and on the left and right side. All these were placed under direct visualization. Pelvic cavity was examined with findings as noted above. The left

utero-ovarian ligament was grasped and cauterized using the Gyrus. Part of the superior aspect of the broad ligament was then cauterized as well. Following this the anterior peritoneum over the bladder flap was incised and the bladder flap bluntly resected off the lower uterine segment. The remainder of the broad and cardinal ligament was then cauterized and excised. A similar procedure was performed on the right side. The cardinal ligament was resected all the way down to 1 cm above the uterosacral ligament. After assuring that the bladder was well out of the way of the operative field, bipolar cautery was used to incise the cervix at a level just above the uterosacral ligaments. The area was irrigated extensively and cautery used to assure hemostasis. A 15 mm probe was then placed on the right side and the uterine morcellator was used to remove the specimen and submitted to pathology for examination. Hemostasis was again confirmed under low pressure. Using Carter-Thomason the fascia was closed in the 15 mm port site with 0 Vicryl suture. The accessory ports were removed and abdomen deflated and skin edges reapproximated with 5-0 Monocryl suture. Instruments removed from vagina. Patient returned to supine position, recalled from general anesthesia and transferred to recovery in satisfactory condition. Sponge and needle counts correct at the conclusion of the case. Estimated blood loss was 30 cc. There were no complications.