PREOPERATIVE DIAGNOSIS: , Incidental right adnexal mass on ultrasound.,POSTOPERATIVE DIAGNOSES:,1. Complex left ovarian cyst.,2. Bilateral complex adnexae.,3. Bilateral hydrosalpinx.,4. Chronic pelvic inflammatory disease.,5. Massive pelvic adhesions.,PROCEDURE PERFORMED:,1. Dilation and curettage (D&C;).,2. Laparoscopy.,3. Enterolysis.,4. Lysis of the pelvic adhesions.,5. Left salpingo-oophorectomy.,ANESTHESIA: ,General.,COMPLICATIONS: , None.,SPECIMENS: , Endometrial curettings and left ovarian mass.,ESTIMATED BLOOD LOSS: , Less than 100 cc.,DRAINS:, None.,FINDINGS: , On bimanual exam, the patient has a slightly enlarged, anteverted, freely mobile uterus with an enlarged left adnexa. Laparoscopically, the patient has massive pelvic adhesions with completely obliterated posterior cul-de-sac and adnexa.,No adnexal structures were initially able to be visualized until after the lysis of adhesions. Eventually we found a normal appearing right ovary, severely scarred right and left fallopian tubes, and a enlarged complex cystic left ovary. There was a normal-appearing appendix and liver, and the vesicouterine junction appeared within normal limits. There were significant adhesions from the small bowel to the bilateral adnexa in the posterior surface of the uterus.,PROCEDURE: ,The patient was taken to the operating room where a general anesthetic was administered. She was then positioned in the dorsal lithotomy position and prepped and draped in the normal sterile fashion. Once the anesthetic was found to be adequate, a bimanual exam was

performed under anesthetic. Next, a weighted speculum was placed in the vagina and anterior wall of the vagina was elevated with the uterine sound and the anterior lip of the cervix was grasped with a vulsellum tenaculum. The uterus was then sounded to 12 cm. The cervix was then serially dilated with Hank dilators to a size #20 Hank. Next a Telfa pad was placed on the weighted speculum and a short curettage was performed obtaining a large amount of endometrial tissue. Next, the uterine manipulator was placed in the cervix and attached to the anterior lip of the cervix. At this point, the vulsellum tenaculum and weighted speculum were removed. Next, attention was turned to the abdomen where an approximately 2 cm incision was made immediately inferior to the umbilicus. The superior aspect of the umbilicus was grasped with a towel clamp and Veress needle was inserted through this incision. Small amount of normal saline was injected into Veress needle and seemed to drop freely. So, the Veress needle was connected to he CO2 gas, which was started at the lower setting. It was seen to flow freely with a normal resistance so the gas was advanced to the higher setting. The abdomen was then insufflated to an adequate distention. Next, the Veress needle was removed and a size #11 step trocar was inserted. Next, the introducer was removed from the trocar and the laparoscope was inserted through this port and the port was also connected to the CO2 gas. At this point, the initial operative findings were seen. Next, a size #5 step trocar was inserted approximately two fingerbreadths above the pubic symphysis in the midline. This

was done by making a 1 cm incision with the skin knife, introducing a Veress needle with Ethicon sheet, and the Veress needle was then removed and the #5 port was introduced under direct visualization. A size #5 port was also placed approximately six fingerbreadths to the right of the umbilicus in a similar manner also under direct visualization. A blunt probe was inserted suprapubically along with a grasper in the right upper quadrant. These were used to see the above operative findings. Next, a size #12 mm port was introduced approximately seven fingerbreadths to the left of the umbilicus under direct visualization. Through this, a Harmonic scalpel was inserted.,The Harmonic scalpel along with the grasper was used to meticulously address the adhesions along the right adnexa in the posterior cul-de-sac. Care was taken at all times to avoid the bowel and the ureters. The fallopian tubes appeared massively scarred and completely obliterated from disease. After the right adnexa had been freed to the point where we could visualize the ovary and the posterior cul-de-sac was clearing off then we could visualize the uterosacral ligaments. Attention was turned to the left adnexa, which appeared to contain a cystic structure, but it was unclear at the beginning of the procedure what the structure was. Adhesions were carefully taken down from the bowel to the left fallopian tube and ovary, and sidewall. The adhesions were then carefully removed from the inferior aspect of the ovary also with the Harmonic scalpel. At intermittent points throughout the procedure, the suction irrigator was used to irrigate and suck blood and irrigation out

of the pelvis to watch for any bleeding. At this point, the Harmonic scalpel was removed and another laparoscopic needle with a 60 cc syringe was inserted and this was used to aspirate approximately 30 cc of serosanguineous fluid from the cystic structure. Next, the needle was removed and the ligature device was inserted. This was used to clamp across the fallopian tube initially and then after the fallopian tube was ligated, the uterovarian ligament was clamped and ligated with the ligature device. Next, the fallopian tube was removed from the ovary with the ligature device in approximately 3 clamping and ligations. Then, the attention was turned to the inferior aspect of the ovary. First the infundibulopelvic ligament was identified, clamped with a ligature device, and ligated. Next, the ovary was bluntly dissected from the ovarian fossa with attention to the left ureter. Next, the ligature device was used to clamp and ligate the broad ligament immediately inferior to the ovary across. Then the ovary was completely bluntly dissected out of the ovarian fossa and completely separated from the pelvis. This was grasped with a clamp. The ligature device was removed from the #12 and a EndoCatch bag was inserted to the size #12 port. The left ovary was placed in this EndoCatch bag, which was then removed along with the whole port from the left upper quadrant. Next, the pelvis was copiously irrigated and suctioned of all blood and extra fluid. At this point, the remaining two size #5 ports were removed under direct visualization. The camera was removed and the abdomen was desufflated. Next, an introducer was replaced on a #11

port. The #11 port was removed. Next, the fascia in the left upper quadrant port was identified and grasped with Ochsner clamps, tented up, and closed with a single interrupted suture of #0 Vicryl on a UR-6 needle. Next, all skin incisions were closed with #4-0 undyed Vicryl in a subcuticular interrupted fashion. The incisions were cleaned, injected with 0.25% Marcaine, and then adjusted with Steri-Strips and bandage appropriately.,The patient was taken from the operating room in stable condition and should be observed overnight in the hospital.