PREOPERATIVE DIAGNOSES:,1. Severe menometrorrhagia unresponsive to medical therapy.,2. Anemia.,3. Symptomatic fibroid uterus.,POSTOPERATIVE DIAGNOSES:,1. Severe menometrorrhagia unresponsive to medical therapy.,2. Anemia.,3. Symptomatic fibroid uterus.,PROCEDURE: , Total abdominal hysterectomy.,ANESTHESIA: ,General.,ESTIMATED BLOOD LOSS: , 150 mL.,COMPLICATIONS: , None.,FINDING: ,Large fibroid uterus.,PROCEDURE IN DETAIL: ,The patient was prepped and draped in the usual sterile fashion for an abdominal procedure. A scalpel was used to make a Pfannenstiel skin incision, which was carried down sharply through the subcutaneous tissue to the fascia. The fascia was nicked in the midline and incision was carried laterally bilaterally with curved Mayo scissors. The fascia was then bluntly and sharply dissected free from the underlying rectus abdominis muscles. The rectus abdominis muscles were then bluntly dissected in the midline and this incision was carried forward inferiorly and superiorly with care taken to avoid bladder and bowel. The peritoneum was then bluntly entered and this incision was carried forward inferiorly and superiorly with care taken to avoid bladder and bowel. The O'Connor-O'Sullivan instrument was then placed without difficulty. The uterus was grasped with a thyroid clamp and the entire pelvis was then visualized without difficulty. The GIA stapling instrument was then used to separate the infundibulopelvic ligament in a ligated fashion from the body of the uterus. This was performed on the left infundibulopelvic ligament and the right

infundibulopelvic ligament without difficulty. Hemostasis was noted at this point of the procedure. The bladder flap was then developed free from the uterus without difficulty. Careful dissection of the uterus from the pedicle with the uterine arteries and cardinal ligaments was then performed using #1 chromic suture ligature in an interrupted fashion on the left and right side. This was done without difficulty. The uterine fundus was then separated from the uterine cervix without difficulty. This specimen was sent to pathology for identification. The cervix was then developed with careful dissection. Jorgenson scissors were then used to remove the cervix from the vaginal cuff. This was sent to pathology for identification. Hemostasis was noted at this point of the procedure. A #1 chromic suture ligature was then used in running fashion at the angles and along the cuff. Hemostasis was again noted. Figure-of-eight sutures were then used in an interrupted fashion to close the cuff. Hemostasis was again noted. The entire pelvis was washed. Hemostasis was noted. The peritoneum was then closed using 2-0 chromic suture ligature in running pursestring fashion. The rectus abdominis muscles were approximated using #1 chromic suture ligature in an interrupted fashion. The fascia was closed using 0 Vicryl in interlocking running fashion. Foundation sutures were then placed in an interrupted fashion for further closing the fascia. The skin was closed with staple gun. Sponge and needle counts were noted to be correct x2 at the end of the procedure. Instrument count was noted to be correct x2 at the end of the procedure. Hemostasis was noted at each level of

closure. The patient tolerated the procedure well and went to recovery room in good condition.