

PREOPERATIVE DIAGNOSIS:, Cervical adenocarcinoma, stage I.,POSTOPERATIVE DIAGNOSIS: , Cervical adenocarcinoma, stage I.,OPERATION PERFORMED:, Exploratory laparotomy, radical hysterectomy, bilateral ovarian transposition, pelvic and obturator lymphadenectomy.,ANESTHESIA: , General, endotracheal tube.,SPECIMENS: , Uterus with attached parametrium and upper vagina, right and left pelvic and obturator lymph nodes.,INDICATIONS FOR PROCEDURE:, The patient recently underwent a cone biopsy at which time invasive adenocarcinoma of the cervix was noted. She was advised regarding treatment options including radical hysterectomy versus radiation and the former was recommended.

,FINDINGS: , During the examination under anesthesia, the cervix was noted to be healing well from recent cone biopsy and no nodularity was noted in the supporting ligaments. During the exploratory laparotomy, there was no evidence of disease extension into the broad ligament or bladder flap. There was no evidence of intraperitoneal spread or lymphadenopathy. ,OPERATIVE PROCEDURE: ,The patient was brought to the Operating Room with an IV in place. Anesthetic was administered after which she was examined under anesthesia. The vagina was then prepped and a Foley catheter was placed. She was prepped and draped. A Pfannenstiel incision was made three centimeters above the symphysis pubis. The peritoneum was entered and the abdomen was explored with findings as noted. The Bookwalter retractor was placed, and bowel was packed.

Clamps were placed on the broad ligament for traction. The retroperitoneum was opened by incising lateral and parallel to the infundibulopelvic ligaments. The round ligaments were isolated, divided and ligated. The peritoneum overlying the vesicouterine fold was incised, and the bladder was mobilized using sharp dissection. The pararectal and paravesical spaces were opened, and the broad ligament was palpated with no evidence of suspicious findings or disease extension. The utero-ovarian ligaments were then isolated, divided and doubly ligated. Tubes and ovaries were mobilized. The ureters were dissected free from the medial leaf of the peritoneum. When the crossover of the uterine artery was reached, and the artery was isolated at its origin, divided and ligated. The uterine artery pedicle was dissected anteriorly over the ureter. The ureter was tunneled through the broad ligament using right angle clamps for tunneling after which each pedicle was divided and ligated. This was continued until the insertion point of the ureter into the bladder trigone. The peritoneum across the cul-de-sac was divided, and the rectovaginal space was opened. Clamps were placed on the uterosacral ligaments at their point of origin. Tissues were divided and suture ligated. Clamps were placed on the paravaginal tissues, which were then divided, and suture ligated. The vagina was then clamped and divided at the junction between the middle and upper third. The vaginal vault was closed with interrupted figure-of-eight stitches. Excellent hemostasis was noted., Retractors were repositioned in the retroperitoneum for the lymphadenectomy. The borders of

dissection included the bifurcation of the common iliac artery superiorly, the crossover of the deep circumflex iliac vein over the external iliac artery inferiorly, the psoas muscle laterally and the anterior division of the hypogastric artery medially. The obturator nerves were carefully isolated and preserved bilaterally and served as the posterior border of dissection. Ligaclips were applied where necessary. After removal of the lymph node specimens, the pelvis was irrigated. The ovaries were transposed above the pelvic brim using running stitches. Packs and retractors were removed, and peritoneum was closed with a running stitch. Subcutaneous tissues were irrigated, and fascia was closed with a running mass stitch using delayed absorbable suture. Subcutaneous adipose was irrigated, and Scarpa's fascia was closed with a running stitch. Skin was closed with a running subcuticular stitch. Final sponge, needle, and instrument counts were correct at the completion of the procedure. The patient was awakened from the anesthetic and taken to the Post Anesthesia Care Unit in stable condition.