PREOPERATIVE DIAGNOSES:,1. Pelvic pain.,2. Hypermenorrhea.,POSTOPERATIVE DIAGNOSES:,1. Pelvic pain.,2. Hypermenorrhea.,3. Mild pelvic endometriosis.,PROCEDURE PERFORMED:,1. Dilatation and curettage (D&C;).,2. Laparoscopic ablation of endometrial implants.,ANESTHESIA: ,General endotracheal.,COMPLICATIONS: , None.,ESTIMATED BLOOD LOSS: , Less than 50 cc.,SPECIMEN: , Endometrial curettings.,INDICATIONS: , This is a 26-year-old female with a history of approximately one year of heavy painful menses. She did complain of some dyspareunia and wants a definitive diagnosis.,FINDINGS: , On bimanual exam, the uterus is small and anteverted with mildly decreased mobility on the left side. There are no adnexal masses appreciated. On laparoscopic exam, the uterus is normal appearing but slightly compressible. The bilateral tubes and ovaries appear normal. There is evidence of endometriosis on the left pelvic sidewall in the posterior cul-de-sac. There was no endometriosis in the right pelvic sidewall or along the bladder flap.,There were some adhesions on the right abdominal sidewall from the previous appendectomy. The liver margin, gallbladder, and bowel appeared normal. The uterus was sounded to 9 cm.,PROCEDURE: , After consent was obtained, the patient was taken to the operating room and general anesthetic was administered. The patient was placed in dorsal lithotomy position and prepped and draped in normal sterile fashion. Sterile speculum was placed in the patient's vagina. The anterior lip of the cervix was grasped with vulsellum

tenaculum. The uterus was sounded to 9 cm. The cervix was then serially dilated with Hank dilators. A sharp curettage was performed until a gritty texture was noted in all aspects of the endometrium. The moderate amount of tissue that was obtained was sent to Pathology. The #20 Hank dilator was then replaced and the sterile speculum was removed. Gloves were changed and attention was then turned to the abdomen where approximately 10 mm transverse infraumbilical incision was made. The Veress needle was placed into this incision and the gas was turned on. When good flow and low abdominal pressures were noted, the gas was turned up and the abdomen was allowed to insufflate. The #11 mm trocar was then placed through this incision and a camera was placed with the above findings noted. A Bierman needle was placed 2 cm superior to the pubic bone and along the midline to allow a better visualization of the pelvic organs. A 5 mm port was placed approximately 7 cm to 8 cm to the right of the umbilicus and approximately 3 cm inferior. The harmonic scalpel was placed through this port and the areas of endometriosis were ablated using the harmonic scalpel. A syringe was placed on to the Bierman needle and a small amount of fluid in the posterior cul-de-sac was removed to allow better visualization of the posterior cul-de-sac. The lesions in the posterior cul-de-sac were then ablated using the Harmonic scalpel. All instruments were then removed. The Bierman needle and 5 mm port was removed under direct visualization with excellent hemostasis noted. The camera was removed and the abdomen was allowed to desufflate.

The 11 mm trocar introducer was replaced and the trocar was removed. The skin was closed with #4-0 undyed Vicryl in subcuticular fashion. ,Approximately 10 cc of 0.25% Marcaine was placed in the incision sites. The dilator and vulsellum tenaculum were removed from the patient's cervix with excellent hemostasis noted. The patient tolerated the procedure well. Sponge, lap, and needle counts were correct at the end of procedure. The patient was taken to the recovery room in satisfactory condition. She will be discharged home with a prescription for Darvocet for pain and is instructed to follow up in the office in two weeks with further treatment will be discussed including approximately six months of continuous monophasic oral contraceptives.