PREOPERATIVE DIAGNOSES:,1. Pelvic pain.,2. Ectopic pregnancy.,POSTOPERATIVE DIAGNOSES:,1. Pelvic pain.,2. Ectopic pregnancy.,3. Hemoperitoneum.,PROCEDURES PERFORMED:,1. Dilation and curettage (D&C;).,2. Laparoscopy.,3. Right salpingectomy.,4. Lysis of adhesions.,5. Evacuation of hemoperitoneum.,ANESTHESIA: , General endotracheal.,ESTIMATED BLOOD LOSS: , Scant from the operation, however, there was approximately 2 liters of clotted and old blood in the abdomen.,SPECIMENS:, Endometrial curettings and right fallopian tube.,COMPLICATIONS: , None.,FINDINGS: , On bimanual exam, the patient has a small anteverted uterus, it is freely mobile. No adnexal masses, however, were appreciated on the bimanual exam. Laparoscopically, the patient had numerous omental adhesions to the vesicouterine peritoneum in the fundus of the uterus. There were also adhesions to the left fallopian tube and the right fallopian tube. There was a copious amount of blood in the abdomen approximately 2 liters of clotted and unclotted blood. There was some questionable gestational tissue _____ on the left sacrospinous ligament. There was an apparent rupture and bleeding ectopic pregnancy in the isthmus portion of the right fallopian tube.,PROCEDURE:, After an informed consent was obtained, the patient was taken to the operating room and the 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. A weighted speculum was then placed in the vagina. The interior wall of vagina elevated with the uterine sound and the anterior lip of the cervix was grasped with the vulsellum tenaculum. The cervix was then serially dilated with Hank dilators to a size #20 Hank and then a sharp curettage was performed obtaining a moderate amount of decidual appearing tissue and the tissue was then sent to pathology. At this point, the uterine manipulator was placed in the cervix and attached to the anterior cervix and vulsellum tenaculum and weighted speculum were removed. Next, attention was then turned to the abdomen. The surgeons all are removed the dirty gloves in the previous portion of the case. Next, a 2 cm incision was made immediately inferior to umbilicus. The superior aspect of the umbilicus was grasped with a towel clamp and a Veress needle was inserted through this incision. Next, a syringe was used to inject normal saline into the Veress needle. The normal saline was seen to drop freely, so a Veress needle was connected to the CO2 gas which was started at its lowest setting. The gas was seen to flow freely with normal resistance, so the CO2 gas was advanced to a higher setting. The abdomen was insufflated to an adequate distension. Once an adequate distention was reached, the CO2 gas was disconnected. The Veress needle was removed and a size #11 step trocar was placed. The introducer was removed and the trocar was connected to the CO2 gas and a camera was inserted. Next, a 1 cm incision was made in the midline approximately two fingerbreadths below the pubic symphysis

after transilluminating with the camera. A Veress needle and a step sheath were inserted through this incision. Next, the Veress needle was removed and a size #5 trocar was inserted under direct visualization. Next a size #5 port was placed approximately five fingerbreadths to the left of the umbilicus in a similar fashion. A size #12 port was placed in a similar fashion approximately six fingerbreadths to the right of the umbilicus and also under direct visualization. The laparoscopic dissector was inserted through the suprapubic port and this was used to dissect the omental adhesions bluntly from the vesicouterine peritoneum and the bilateral fallopian tubes. Next, the Dorsey suction irrigator was used to copiously irrigate the abdomen. Approximate total of 3 liters of irrigation was used and the majority of all blood clots and free blood was removed from the abdomen.,Once the majority of blood was cleaned from the abdomen, the ectopic pregnancy was easily identified and the end of the fallopian tube was grasped with the grasper from the left upper quadrant and the LigaSure device was then inserted through the right upper quadrant with # 12 port. Three bites with the LigaSure device were used to transect the mesosalpinx inferior to the fallopian tube and then transect the fallopian tube proximal to the ectopic pregnancy. An EndoCatch bag was then placed to the size #12 port and this was used to remove the right fallopian tube and ectopic pregnancy. This was then sent to the pathology. Next, the right mesosalpinx and remains of the fallopian tube were examined again and they were seemed to be hemostatic. The abdomen was further irrigated. The liver

was examined and appeared to be within normal limits. At this point, the two size #5 ports and a size #12 port were removed under direct visualization. The camera was then removed. The CO2 gas was disconnected and the abdomen was desufflated. The introducer was then replaced in a size #11 port and the whole port and introducer was removed as a single unit. All laparoscopic incisions were closed with a #4-0 undyed Vicryl in a subcuticular interrupted fashion. They were then steri-stripped and bandaged appropriately. At the end of the procedure, the uterine manipulator was removed from the cervix and the patient was taken to Recovery in stable condition. The patient tolerated the procedure well. Sponge, lap, and needle counts were correct x2. She was discharged home with a postoperative hemoglobin of 8.9. She was given iron 325 mg to be taken twice a day for five months and Darvocet-N 100 mg to be taken every four to six hours for pain. She will follow up within a week in the OB resident clinic.