PREOPERATIVE DIAGNOSES:,1. Chronic pelvic pain.,2. Endometriosis.,3. Prior right salpingo-oophorectomy.,4. History of intrauterine device perforation and exploratory surgery.,POSTOPERATIVE DIAGNOSES:,1. Endometriosis.,2. Interloop bowel adhesions.,PROCEDURE PERFORMED:,1. Total abdominal hysterectomy (TAH).,2. Left salpingo-oophorectomy.,3. Lysis of interloop bowel adhesions.,ANESTHESIA:, General.,ESTIMATED BLOOD LOSS: ,400 cc.,FLUIDS: , 2300 cc of lactated Ringers, as well as lactated Ringers for intraoperative irrigation.,URINE: , 500 cc of clear urine output.,INTRAOPERATIVE FINDINGS: , The vulva and perineum are without lesions. On bimanual exam, the uterus was enlarged, movable, and anteverted. The intraabdominal findings revealed normal liver margin, kidneys, and stomach upon palpation. The uterus was found to be normal in size with evidence of endometriosis on the uterus. The right ovary and fallopian tube were absent. The left fallopian tube and ovary appeared normal with evidence of a small functional cyst. There was evidence of left adnexal adhesion to the pelvic side wall which was filmy, unable to be bluntly dissected. There were multiple interloop bowel adhesions that were filmy in nature noted.,The appendix was absent. There did appear to be old suture in a portion of the bowel most likely from a prior procedure.,INDICATIONS: , This patient is a 45-year-old African-American gravida7, para3-0-0-3, who is here for definitive treatment of chronic pelvic pain with a history of endometriosis. She did have a laparoscopic ablation of endometriosis on a laparoscopy and

also has a history of right salpingo-oophorectomy. She has tried Lupron and did stop secondary to the side effects.,PROCEDURE IN DETAIL: , After informed consent was obtained in layman's terms, the patient was taken back to the Operating Suite and placed under general anesthesia. She was then prepped and draped in the sterile fashion and placed in the dorsal supine position. An indwelling Foley catheter was placed. With the skin knife, an incision was made removing the old cicatrix. A Bovie was used to carry the tissue through to the underlying layer of the fascia which was incised in the midline and extended with the Bovie. The rectus muscle was then sharply and bluntly dissected off the superior aspect of the rectus fascia in the superior as well as the inferior aspect using the Bovie. The rectus muscle was then separated in the midline using a hemostat and the peritoneum was entered bluntly. The peritoneal incision was then extended superiorly and inferiorly with Metzenbaum scissors with careful visualization of the bladder. At this point, the intraabdominal cavity was manually explored and the above findings were noted. A Lahey clamp was then placed on the fundus of the uterus and the uterus was brought to the surgical field. The bowel was then packed with moist laparotomy sponges. Prior to this, the filmy adhesions leftover were taken down. At this point, the left round ligament was identified, grasped with two hemostats, transected, and suture ligated with #0 Vicryl. At this point, the broad ligament was dissected down and the lost portion of the bladder flap was created. The posterior aspect of the peritoneum was also

dissected. At this point, the infundibulopelvic ligament was isolated and three tie of #0 Vicryl was used to isolate the pedicle. Two hemostats were then placed across the pedicle and this was transected with the scalpel. This was then suture ligated in Heaney fashion. The right round ligament was then identified and in the similar fashion, two hemostats were placed across the round ligament and using the Mayo scissors the round ligament was transected and dissected down the broad ligament to create the bladder flap anteriorly as well as dissect the posterior peritoneum and isolate the round ligament. This was then ligated with three tie of #0 Vicryl. Also incorporated in this was the remnant from the previous right salpingo-oophorectomy. At this point, the bladder flap was further created with sharp dissection as well as the moist Ray-Tech to push the bladder down off the anterior portion of the cervix.,The left uterine artery was then skeletonized and a straight Heaney was placed. In a similar fashion, the contralateral uterine artery was skeletonized and straight Heaney clamp was placed. These ligaments bilaterally were transected and suture ligated in a left Heaney stitch. At this point, curved Masterson was used to incorporate the cardinal ligament complex, thus was transected and suture ligated. Straight Masterson was then used to incorporate the uterosacrals bilaterally and this was also transected and suture ligated. Prior to ligating the uterine arteries, the uterosacral arteries were tagged bilaterally with #0 Vicryl. At this point, the roticulator was placed across the vaginal cuff and snug underneath the entire cervix. The

roticulator was then clamped and removed and the staple line was in place. This was found to be hemostatic. A suture was then placed through each cuff angle bilaterally and cardinal ligament complex was found to be fixed to each apex bilaterally. At this point, McCall culdoplasty was performed with an #0 Vicryl incorporating each uterosacral as well as the posterior peritoneum. There did appear to be good support on palpation. Prior to this, the specimen was handed off and sent to pathology. At this point, there did appear to be small amount of oozing at the right peritoneum. Hemostasis was obtained using a #0 Vicryl in two single stitches. Good hemostasis was then obtained on the cuff as well as the pedicles. Copious irrigation was performed at this point with lactate Ringers. The round ligaments were then incorporated into the cuff bilaterally. Again, copious amount of irrigation was performed and good hemostasis was obtained. At this point, the peritoneum was reapproximated in a single interrupted stitch on the left and right lateral aspects to cover each pedicle bilaterally. At this point, the bowel packing as well as moist Ray-Tech was removed and while re-approximating the bowel it was noted that there were multiple interloop bowel adhesions which were taken down using the Metzenbaum scissors with good visualization of the underlying bowel. Good hemostasis was obtained of these sites as well. The sigmoid colon was then returned to its anatomic position and the omentum as well. The rectus muscle was then reapproximated with two interrupted sutures of #2-0 Vicryl. The fascia was then reapproximated with #0

Vicryl in a running fashion from lateral to medial meeting in the midline. The Scarpa's fascia was then closed with #3-0 plain in a running suture. The skin was then re-approximated with #4-0 undyed Vicryl in a subcuticular closure. This was dressed with an Op-Site. The patient tolerated the procedure well. The sponge, lap, and needle were correct x2. After the procedure, the patient was extubated and brought out of general anesthesia. She will go to the floor where she will be followed postoperatively in the hospital.