PREOPERATIVE DIAGNOSIS: , Complex right lower quadrant mass with possible ectopic pregnancy.,POSTOPERATIVE DIAGNOSES:,1. Right ruptured tubal pregnancy.,2. Pelvic adhesions.,PROCEDURE PERFORMED:,1. Dilatation and curettage.,2. Laparoscopy with removal of tubal pregnancy and right partial salpingectomy.,ANESTHESIA: ,General.,ESTIMATED BLOOD LOSS: ,Less than 100 cc.,COMPLICATIONS: , None.,INDICATIONS: , The patient is a 25-year-old African-American female, gravida 7, para-1-0-5-1 with two prior spontaneous abortions with three terminations who presents with pelvic pain. She does have a slowly increasing beta HCG starting at 500 to 849 and the max to 900. Ultrasound showed a complex right lower quadrant mass with free fluid in the pelvis. It was decided to perform a laparoscopy for the possibility of an ectopic pregnancy.,FINDINGS: , On bimanual exam, the uterus was approximately 10 weeks' in size, mobile, and anteverted. There were no adnexal masses appreciated although there was some fullness in the right lower quadrant. The cervical os appeared parous.,Laparoscopic findings revealed a right ectopic pregnancy, which was just distal to the right fallopian tube and attached to the fimbria as well as adherent to the right ovary. There were some pelvic adhesions in the right abdominal wall as well. The left fallopian tube and ovary and uterus appeared normal. There was no evidence of endometriosis. There was a small amount of blood in the posterior cul-de-sac.,PROCEDURE IN DETAIL: , After

informed consent was obtained in layman's terms, the patient was taken back to the operating suite, prepped and draped, placed under general anesthesia, and placed in the dorsal lithotomy position. The bimanual exam was performed, which revealed the above findings. A weighted speculum was placed in the patient's posterior vaginal vault and the 12 o' clock position of the cervix was grasped with the vulsellum tenaculum. The cervix was then serially dilated using Hank dilators up to a #10. A sharp curette was then introduced and curettage was performed obtaining a mild amount of tissue. The tissue was sent to pathology for evaluation. The uterine elevator was then placed in the patient's cervix. Gloves were changed. The attention was turned to the anterior abdominal wall where a 1 cm infraumbilical skin incision was made. While tenting up the abdominal wall, the Veress needle was placed without difficulty. The abdomen was then insufflated with appropriate volume and flow of CO2. The #11 step trocar was then placed without difficulty in abdominal wall. The placement was confirmed with a laparoscope. It was then decided to put a #5 step trocar approximately 2 cm above the pubis symphysis in order to manipulate the pelvic contents. The above findings were then noted. Because the tubal pregnancy was adherent to the ovary, an additional port was placed in the right lateral aspect of the patient's abdomen. A #12 step trocar port was placed under direct visualization. Using a grasper, Nezhat-Dorsey suction irrigator, the mass was hydro-dissected off of the right ovary and further shelled away with graspers. This was removed with the gallbladder

grasper through the right lateral port site. There was a small amount of oozing at the distal portion of the fimbria where the mass has been attached. Partial salpingectomy was therefore performed. This was done using the LigaSure. The LigaSure was clamped across the portion of the tube including distal tube and ligated and transected. Good hemostasis was obtained in all of the right adnexal structures. The pelvis was then copiously suction irrigated. The area again was then visualized and again found to be hemostatic. The instruments were then removed from the patient's abdomen under direct visualization. The abdomen was then desufflated and the #11 step trocar was removed. The incisions were then repaired with #4-0 undyed Vicryl and dressed with Steri-Strips. The uterine elevator was removed from the patient's vagina.,The patient tolerated the procedure well. The sponge, lap, and needle count were correct x2. She will follow up postoperatively as an outpatient.