PREOPERATIVE DIAGNOSES:,1. Hypermenorrhea.,2. Uterine fibroids.,3. Pelvic pain.,4. Left adnexal mass.,5. Pelvic adhesions.,POSTOPERATIVE DIAGNOSES:,1. Hypermenorrhea.,2. Uterine fibroids.,3. Pelvic pain.,4. Left adnexal mass.,5. Pelvic adhesions.,PROCEDURE PERFORMED:,1. Total abdominal hysterectomy (TAH).,2. Left salpingo-oophorectomy.,ANESTHESIA:, General endotracheal.,COMPLICATIONS:, None.,ESTIMATED BLOOD LOSS: , Less than 100 cc.,INDICATIONS: , The patient is a 47-year-old Caucasian female with complaints of hypermenorrhea and pelvic pain, noted to have a left ovarian mass 7 cm at the time of laparoscopy in July of 2003. The patient with continued symptoms of pelvic pain and hypermenorrhea and desired definitive surgical treatment.,FINDINGS AT THE TIME OF SURGERY: , Uterus is anteverted and boggy with a very narrow introitus with a palpable left adnexal mass.,On laparotomy, the uterus was noted to be slightly enlarged with fibroid change as well as a hemorrhagic appearing left adnexal mass. The bowel, omentum, and appendix had a normal appearance.,PROCEDURE: , The patient was taken to the operative suite where anesthesia was found to be adequate. She was then prepared and draped in normal sterile fashion. A Pfannenstiel skin incision was made with a scalpel and carried through the underlying layer of fascia with the second scalpel. The fascia was then incised in the midline. The fascial incision was then extended laterally with Mayo scissors. The superior aspect of the fascial incision was grasped with

Kochers with the underlying rectus muscle dissected off bluntly and sharply with Mayo scissors. Attention was then turned to the inferior aspect of this incision, which in a similar fashion was tented up with the underlying rectus muscle and dissected off bluntly and sharply with Mayo scissors. The rectus muscle was then separated in the midline. The peritoneum was identified, tented up with hemostats and entered sharply with Metzenbaum scissors. The peritoneal incision was then extended superiorly and inferiorly with good visualization of the bladder. The uterus and left adnexa were then palpated and brought out into the surgical field. The fundus of the uterus was grasped with a Lahey clamp. The GYN/Balfour retractor was placed. The bladder blade was placed. The bowel was packed away with moist laparotomy sponges and the extension through GYN/Balfour retractor was placed. At this time, the patient's anatomy was surveyed and there was found to be a left hemorrhagic appearing adnexal mass. Attention was first turned to the right round ligament, which was tented up with a Babcock and a small window was made beneath the round ligament with a hemostat. It was then suture ligated with #0 Vicryl suture, transected with the broad ligament being skeletonized on both sides. Next, the right _____ was isolated bluntly as the patient had a previous RSO. This was then suture ligated with #0 Vicryl suture, doubly clamped with Kocher clamps, transected, and suture ligated with #0 Vicryl suture with a Heaney stitch. Attention was then turned to the left round ligament, which was tented up with the Babcock. Small

window was made beneath it and the broad ligament with hemostat was then suture ligated with #0 Vicryl suture, transected, and skeletonized with the aid of Metzenbaums. The left infundibulopelvic ligament was then bluntly isolated. It was then suture ligated with #0 Vicryl suture, doubly clamped with Kocher clamps, and transected and suture ligated with #0 Vicryl suture with a Heaney stitch. The bladder flap was then placed on tension with Allis clamps. It was then dissected off of the lower uterine segment with the aid of Metzenbaum scissors and Russians. It was then gently pushed off of lower uterine segment with the aid of a moist Ray-Tec. The uterine arteries were then skeletonized bilaterally.,They were then clamped with straight Kocher clamps, transected, and suture ligated with #0 Vicryl suture. The cardinal ligament and uterosacral complexes on both sides were then clamped with curved Kocher clamps. These were then transected and suture ligated with #0 Vicryl suture. The lower uterine segment was then grasped with Lahey clamps, at which time the cervix was already visible. It was then entered with the last transection. The cervix was grasped with a single-toothed tenaculum and the uterus, cervix, and left adnexa were amputated off the vagina with the aid of Jorgenson scissors. The angles of the vaginal cuff were then grasped with Kocher clamps. A Betadine-soaked Ray-Tec was then pushed into the vagina and the vaginal cuff was closed with #0 Vicryl suture in a running lock fashion with care taken to transect the ipsilateral cardinal ligament, at which time the suction tip was changed and copious suction irrigation was performed. Good

hemostasis was appreciated. A figure-of-eight suture in the center of the vaginal cuff was placed with #0 Vicryl. This was tagged for later use. The uterosacrals on both sides were incorporated into the vaginal cuff with the aid of #0 Vicryl suture. The round ligaments were then pulled into the vaginal cuff using the figure-of-eight suture placed in the center of the vaginal cuff and these were tied in place. The pelvis was then again copiously suctioned irrigated and hemostasis was appreciated. The peritoneal surfaces were then reapproximated with the aid of #3-0 Vicryl suture in a running fashion. The GYN/Balfour retractor and bladder blade were then removed. The bowel was then packed. Again copious suction irrigation was performed with hemostasis appreciated. The peritoneum was then reapproximated with #2-0 Vicryl suture in a running fashion. The fascia was then reapproximated with #0 Vicryl suture in a running fashion. The Scarpa's fascia was then reapproximated with #3-0 plain gut in a running fashion and the skin was closed with #4-0 undyed Vicryl in a subcuticular fashion. Steri-Strips were placed. At the end of the procedure, the sponge that was pushed into the vagina previously was removed and hemostasis was appreciated vaginally. The patient tolerated the procedure well and was taken to Recovery in stable condition. Sponge, lap, and needle counts were correct x2. Specimens include uterus, cervix, left fallopian tube, and ovary.