PREOPERATIVE DIAGNOSES,1. Abnormal uterine bleeding.,2. Uterine fibroids.,POSTOPERATIVE DIAGNOSES,1. Abnormal uterine bleeding.,2. Uterine fibroids.,OPERATION PERFORMED: , Laparoscopic-assisted vaginal hysterectomy.,ANESTHESIA: , General endotracheal anesthesia.,DESCRIPTION OF PROCEDURE: ,After adequate general endotracheal anesthesia, the patient was placed in dorsal lithotomy position, prepped and draped in the usual manner for a laparoscopic procedure. A speculum was placed into the vagina. A single tooth tenaculum was utilized to grasp the anterior lip of the uterine cervix. The uterus was sounded to 10.5 cm. A #10 RUMI cannula was utilized and attached for uterine manipulation. The single-tooth tenaculum and speculum were removed from the vagina. At this time, the infraumbilical area was injected with 0.25% Marcaine with epinephrine and infraumbilical vertical skin incision was made through which a Veress needle was inserted into the abdominal cavity. Aspiration was negative; therefore the abdomen was insufflated with carbon dioxide. After adequate insufflation, Veress needle was removed and an 11-mm separator trocar was introduced through the infraumbilical incision into the abdominal cavity. Through the trocar sheath, the laparoscope was inserted and adequate visualization of the pelvic structures was noted. At this time, the suprapubic area was injected with 0.25% Marcaine with epinephrine. A 5-mm skin incision was made and a 5-mm trocar was introduced into the abdominal cavity for instrumentation. Evaluation of the pelvis revealed the uterus to be slightly

enlarged and irregular. The fallopian tubes have been previously interrupted surgically. The ovaries appeared normal bilaterally. The cul-de-sac was clean without evidence of endometriosis, scarring or adhesions. The ureters were noted to be deep in the pelvis. At this time, the right cornu was grasped and the right fallopian tube, uteroovarian ligament, and round ligaments were doubly coagulated with bipolar electrocautery and transected without difficulty. The remainder of the uterine vessels and anterior and posterior leaves of the broad ligament, as well as the cardinal ligament was coagulated and transected in a serial fashion down to level of the uterine artery. The uterine artery was identified. It was doubly coagulated with bipolar electrocautery and transected. A similar procedure was carried out on the left with the left uterine cornu identified. The left fallopian tube, uteroovarian ligament, and round ligaments were doubly coagulated with bipolar electrocautery and transected. The remainder of the cardinal ligament, uterine vessels, anterior, and posterior sheaths of the broad ligament were coagulated and transected in a serial manner to the level of the uterine artery. The uterine artery was identified. It was doubly coagulated with bipolar electrocautery and transected. The anterior leaf of the broad ligament was then dissected to the midline bilaterally, establishing a bladder flap with a combination of blunt and sharp dissection. At this time, attention was made to the vaginal hysterectomy. The laparoscope was removed and attention was made to the vaginal hysterectomy. The RUMI cannula was removed and

the anterior and posterior leafs of the cervix were grasped with Lahey tenaculum. A circumferential injection with 0.25% Marcaine with epinephrine was made at the cervicovaginal portio. A circumferential incision was then made at the cervicovaginal portio. The anterior and posterior colpotomies were accomplished with a combination of blunt and sharp dissection without difficulty. The right uterosacral ligament was clamped, transected, and ligated with #0 Vicryl sutures. The left uterosacral ligament was clamped, transected, and ligated with #0 Vicryl suture. The parametrial tissue was then clamped bilaterally, transected, and ligated with #0 Vicryl suture bilaterally. The uterus was then removed and passed off the operative field. Laparotomy pack was placed into the pelvis. The pedicles were evaluated. There was no bleeding noted; therefore, the laparotomy pack was removed. The uterosacral ligaments were suture fixated into the vaginal cuff angles with #0 Vicryl sutures. The vaginal cuff was then closed in a running fashion with #0 Vicryl suture. Hemostasis was noted throughout. At this time, the laparoscope was reinserted into the abdomen. The abdomen was reinsufflated. Evaluation revealed no further bleeding. Irrigation with sterile water was performed and again no bleeding was noted. The suprapubic trocar sheath was then removed under laparoscopic visualization. The laparoscope was removed. The carbon dioxide was allowed to escape from the abdomen and the infraumbilical trocar sheath was then removed. The skin incisions were closed with #4-0 Vicryl in subcuticular fashion. Neosporin and Band-Aid were applied for dressing

and the patient was taken to the recovery room in satisfactory condition. Estimated blood loss was approximately 100 mL. There were no complications. The instrument, sponge, and needle counts were correct.