PREOPERATIVE DIAGNOSES:,1. Abnormal uterine bleeding.,2. Status post spontaneous vaginal delivery.,POSTOPERATIVE DIAGNOSES:,1. Abnormal uterine bleeding.,2. Status post spontaneous vaginal delivery.,PROCEDURE PERFORMED:,1. Dilation and curettage (D&C;).,2. Hysteroscopy.,ANESTHESIA: , IV sedation with paracervical block.,ESTIMATED BLOOD LOSS:, Less than 10 cc.,INDICATIONS: ,This is a 17-year-old African-American female that presents 7 months status post spontaneous vaginal delivery without complications at that time. The patient has had abnormal uterine bleeding since her delivery with an ultrasound showing a 6 cm x 6 cm fundal mass suspicious either for retained products or endometrial polyp.,PROCEDURE:, The patient was consented and seen in the preoperative suite. She was taken to the operative suite, placed in a dorsal lithotomy position, and placed under IV sedation. She was prepped and draped in the normal sterile fashion. Her bladder was drained with the red Robinson catheter which produced approximately 100 cc of clear yellow urine. A bimanual exam was done, was performed by Dr. X and Dr. Z. The uterus was found to be anteverted, mobile, fully involuted to a pre-pregnancy stage. The cervix and vagina were grossly normal with no obvious masses or deformities. A weighted speculum was placed in the posterior aspect of the vagina and the anterior lip of the cervix was grasped with the vulsellum tenaculum.,The uterus was sounded to 8 cm. The cervix was sterilely dilated with Hank dilator and then Hagar dilator. At the time of blunt

dilation, it was noticed that the dilator passed posteriorly with greater ease than it had previously. The dilation was discontinued at that time because it was complete and the hysteroscope was placed into the uterus. Under direct visualization, the ostia were within normal limits. The endometrial lining was hyperplastic, however, there was no evidence of retained products or endometrial polyps. The hyperplastic tissue did not appear to have calcification or other abnormalities. There was a small area of the lower uterine segment posteriorly that was suspicious for endometrial perforation, however this area was hemostatic, no evidence of bowel involvement and was approximately 1 x 1 cm in nature. The hysteroscope was removed and a sharp curette was placed intrauterine very carefully using a anterior wall for guidance. Endometrial curettings were obtained and the posterior aspect suspicious for perforation was gently probed and seemed to have clamped down since the endometrial curetting. The endometrial sampling was placed on Telfa pad and sent to Pathology for evaluation. A rectal exam was performed at the end of the procedure which showed no hematoma formation in the posterior cul-de-sac. There was a normal consistency of the cervix and the normal step-off. The uterine curette was removed as well as the vulsellum tenaculum and the weighted speculum. The cervix was found to be hemostatic. The patient was taken off the dorsal lithotomy position and recovered from her IV sedation in the recovery room. The patient will be sent home once stable from anesthesia. She will be instructed to followup in

the office in two weeks for discussion of the pathologic report of the endometrial curettings. The patient is sent home on Tylenol #3 prescription as she is allergic to Motrin. The patient is instructed to refrain from intercourse douching or using tampons for the next two weeks. The patient is also instructed to contact us if she has any problems with further bleeding, fevers, or difficulty with urination.