PREOPERATIVE DIAGNOSES:,1. Right pelvic pain.,2. Right ovarian mass.,POSTOPERATIVE DIAGNOSES:,1. Right pelvic pain.,2. Right ovarian mass.,3. 8 cm x 10 cm right ovarian cyst with ovarian torsion.,PROCEDURE PERFORMED: ,Laparoscopic right salpingooophorectomy.,ANESTHESIA: ,General with endotracheal tube.,COMPLICATIONS: , None.,ESTIMATED BLOOD LOSS: , Less than 50 cc.,TUBES: , None.,DRAINS:, None.,PATHOLOGY: , The right tube and ovary sent to pathology for review.,FINDINGS: , On exam under anesthesia, a normal-appearing vulva and vagina and normally palpated cervix, a uterus that was normal size, and a large right adnexal mass. Laparoscopic findings demonstrated a 8 cm x 10 cm smooth right ovarian cyst that was noted to be torsed twice. Otherwise, the uterus, left tube and ovary, bowel, liver margins, appendix, and gallbladder were noted all to be within normal limits. There was no noted blood in the pelvis.,INDICATIONS FOR THIS PROCEDURE:, The patient is a 26-year-old G1 P1 who presented to ABCD General Emergency Room with complaint of right lower quadrant pain since last night, which has been increasing in intensity. The pain persisted despite multiple pain medications given in the Emergency Room. The patient reports positive nausea and vomiting. There was no vaginal bleeding or discharge. There was no fevers or chills. Her cultures done in the Emergency Room were pending. The patient did have an ultrasound that demonstrated an 8 cm right ovarian cyst, questionable hemorrhagic. The uterus and left ovary were within normal

limits. There was a positive flow noted to bilateral ovaries on ultrasound. Therefore, it was felt appropriate to take the patient for a diagnostic laparoscopy with a possible oophorectomy.,PROCEDURE:, After informed consent was obtained, and all questions were answered to the patient's satisfaction in layman's terms, she was taken to the operating room where general anesthesia was obtained without any difficulty. She was placed in dorsal lithotomy position with the use of Allis strips and prepped and draped in the usual sterile fashion. Her bladder was drained with a red Robinson catheter and she was examined under anesthesia and was noted to have the findings as above. She was prepped and draped in the usual sterile fashion. A weighted speculum was placed in the patient's vagina with excellent visualization of the cervix. The cervix was grasped at 12 o'clock position with a single-toothed tenaculum and pulled into the operative field. The uterus was then sounded to approximately 3.5 inches and then a uterine elevator was placed. The vulsellum tenaculum was removed. The weighted speculum was removed. Attention was then turned to the abdomen where 1 cm infraumbilical incision was made in the infraumbilical fold. The Veress step needle was then placed into the abdomen while the abdomen was being tented up with towel clamp. The CO2 was then turned on with unoccluded flow and excellent pressures. This was continued till a normal symmetrical pneumoperitoneum was obtained. Then, a #11 mm step trocar and sleeve were placed into the infraumbilical port without any difficulty and placement was confirmed by

laparoscope. Laparoscopic findings are as noted above. A suprapubic incision was made with the knife and then a #12 mm step trocar and sleeve were placed in the suprapubic region under direct visualization. Then, a grasper was used to untorse the ovary. Then, a #12 mm port was placed in the right flank region under direct visualization using a LigaSure vessel sealing system. The right tube and ovary were amputated and noted to be hemostatic. The EndoCatch bag was then placed through the suprapubic port and the ovary was placed into the bag. The ovary was too large to fit completely into the bag. Therefore, a laparoscopic needle with a 60 cc syringe was used to aspirate the contents of the ovary while it was still inside the bag.,There was approximately 200 cc of fluid aspirated from the cyst. This was a clear yellow fluid. Then, the bag was closed and the ovary was removed from the suprapubic port. The suprapubic port did have to be extended somewhat to allow for the removal of the ovary. The trocar and sleeve were then placed back into the port. The abdomen was copiously irrigated with warm normal saline using the Nezhat-Dorsey suction irrigator and the incision site was noted to be hemostatic. The pelvis was clear and clean. ,Pictures were obtained. The suprapubic port was then removed under direct visualization and then using a #0-vicyrl and UR6. Two figure-of-eight sutures were placed in the fascia of suprapubic port and fascia was closed and the pneumoperitoneum was maintained after the sutures were placed. Therefore, the peritoneal surface was noted to be hemostatic. Therefore, the camera was removed. All

instruments were removed. The abdomen was allowed to completely deflate and then the trocars were placed back through the sleeves of the right flank #12 port and the infraumbilical port and these were removed. The infraumbilical port was examined and noted to have a small fascial defect which was repaired with #0-Vicryl and UR6. The right flank area was palpated and there was no facial defect noted. The skin was then closed with #4-0 undyed Vicryl in subcuticular fashion. Dressings were changed. The weighted speculum was removed from the patient's cervix. The cervix noted to be hemostatic. The patient tolerated the procedure well. Sponge, lap, and needle counts were correct x2 and the patient was taken to the Recovery in stable condition.