PREOPERATIVE DIAGNOSES,1. Pelvic mass.,2. Suspected right ovarian cyst.,POSTOPERATIVE DIAGNOSES,1. Pelvic mass.,2. Suspected right ovarian cyst.,PROCEDURES,1. Exploratory laparotomy.,2. Extensive lysis of adhesions.,3. Right salpingo-oophorectomy.,ANESTHESIA:, General.,ESTIMATED BLOOD LOSS: , 200 mL,SPECIMENS: ,Right tube and ovary.,COMPLICATIONS: , None.,FINDINGS: , Extensive adhesive disease with the omentum and bowel walling of the entire pelvis, which required more than 45 minutes of operating time in order to establish visualization and to clear the bowel and other important structures from the ovarian cyst, tube, and ovary in order to remove them. The large and small bowels were completely enveloping a large right ovarian cystic mass. Normal anatomy was difficult to see due to adhesions. Cyst was ruptured incidentally intraoperatively with approximately 150 mL to 200 mL of turbid fluid. Cyst wall, tube, and ovary were stripped away from the bowel. Posterior peritoneum was also removed in order to completely remove the cyst wall ovary and tube. There was excellent postoperative hemostasis.,PROCEDURE: ,The patient was taken to the operating room, where general anesthesia was achieved without difficulty. She was then placed in a dorsal supine position and prepped and draped in the usual sterile fashion. A vertical midline incision was made from the umbilicus and extended to the symphysis pubis along the line of the patient's prior incision. Incision was carried down carefully until the peritoneal cavity was reached. Care was taken upon entry of

the peritoneum to avoid injury of underlying structures. At this point, the extensive adhesive disease was noted, again requiring greater than 45 minutes of dissection in order to visualize the intended anatomy for surgery. The omentum was carefully stripped away from the patient's right side developing a window. This was extended down along the inferior portion of the incision removing the omentum from its adhesions to the anterior peritoneum and what appears to be the vesicouterine peritoneum. A large mass of bowel was noted to be adherent to itself causing a quite tortuous course. Adhesiolysis was performed in order to free up the bowel in order to pack it out of the pelvis. Excellent hemostasis was noted. The bowel was then packed over of the pelvis allowing visualization of a matted mass of large and small bowel surrounding a large ovarian cyst. Careful adhesive lysis and dissection enabled the colon to be separated from the posterior wall of the cyst. Small bowel and portion of the colon were adherent anteriorly on the cyst and during the dissection of these to remove them from their attachment, the cyst was ruptured. Large amount of turbid fluid was noted and was evacuated. The cyst wall was then carefully placed under tension and stripped away from the patient's small and large bowel. Once the bowel was freed, the remnants of round ligament was identified, elevated, and the peritoneum was incised opening the retroperitoneal space.,The retroperitoneal space was opened following the line of the ovarian vessels, which were identified and elevated and a window made inferior to the ovarian vessels, but superior to the course of

the ureter. This pedicle was doubly clamped, transected, and tied with a free tie of #2-0 Vicryl. A suture ligature of #0 Vicryl was used to obtain hemostasis. Excellent hemostasis was noted at this pedicle. The posterior peritoneum and portion of the remaining broad ligament were carefully dissected and shelled out to remove the tube and ovary, which was still densely adherent to the peritoneum. Care was taken at the side of the remnant of the uterine vessels. However, a laceration of the uterine vessels did occur, which was clamped with a right-angle clamp, and carefully sutured ligated with excellent hemostasis noted. Remainder of the specimen was then shelled out including portions of the posterior and sidewall peritoneum and removed.,The opposite tube and ovary were identified, were also matted behind a large amount of large bowel and completely enveloped and wrapped in the fallopian tube. Minimal dissection was performed in order to ascertain and ensure that the ovary appeared completely normal. It was then left in situ. Hemostasis was achieved in the pelvis with the use of electrocautery. The abdomen and pelvis were copiously irrigated with warm saline solution. The peritoneal edges were inspected and found to have good hemostasis after the side of the uterine artery pedicle, and the ovarian vessel pedicle. The areas of the bowel had previously been dissected and due to adhesive disease, it was carefully inspected and excellent hemostasis was noted.,All instruments and packs removed from the patient's abdomen. The abdomen was closed with a running mattress closure of #0 PDS, beginning at the superior

aspect of the incision, and extending inferiorly. Excellent closure of the incision was noted. The subcutaneous tissues were then copiously irrigated. Hemostasis was achieved with the use of cautery. Subcutaneous tissues were reapproximated to close the edge space with a several interrupted sutures of #0 plain gut suture. The skin was closed with staples.,Incision was sterilely clean and dressed. The patient was awakened from general anesthesia and taken to the recovery room in stable condition. All counts were noted correct times three.