PREOPERATIVE DIAGNOSES:,1. Thickened endometrium and tamoxifen therapy.,2. Adnexal cyst.,POSTOPERATIVE DIAGNOSES:,1. Thickened endometrium and tamoxifen therapy.,2. Adnexal cyst.,3. Endometrial polyp.,4. Right ovarian cyst.,PROCEDURE PERFORMED:,1. Dilation and curettage (D&C;).,2. Hysteroscopy.,3. Laparoscopy with right salpingooophorectomy and aspiration of cyst fluid.,ANESTHESIA: , General.,ESTIMATED BLOOD LOSS: , Less than 20 cc.,COMPLICATIONS:, None.,INDICATIONS: , This patient is a 44-year-old gravida 2, para 1-1-1-2 female who was diagnosed with breast cancer in December of 2002. She has subsequently been on tamoxifen. Ultrasound did show a thickened endometrial stripe as well as an adnexal cyst. The above procedures were therefore performed.,FINDINGS: ,On bimanual exam, the uterus was found to be slightly enlarged and anteverted. The external genitalia was normal. Hysteroscopic findings revealed both ostia well visualized and a large polyp on the anterolateral wall of the endometrium. Laparoscopic findings revealed a normal-appearing uterus and normal left ovary. There was no evidence of endometriosis on the ovaries bilaterally, the ovarian fossa, the cul-de-sac, or the vesicouterine peritoneum. There was a cyst on the right ovary which appeared simple in nature. The cyst was aspirated and the fluid was blood tinged. Therefore, the decision to perform oophorectomy was made. The liver margins appeared normal and there were no pelvic or abdominal adhesions noted. The polyp removed from the hysteroscopic portion of the exam

was found to be 4 cm in size.,PROCEDURE IN DETAIL: , After informed consent was obtained in layman's terms, the patient was taken back to the operating suite, prepped and draped and placed in the dorsal lithotomy position. Her bladder was drained with a red Robinson catheter. A bimanual exam was performed, which revealed the above findings. A weighted speculum was then placed in the posterior vaginal vault in the 12 o'clock position and the cervix was grasped with vulsellum tenaculum. The cervix was then sounded in the anteverted position to 10 cm. The cervix was then serially dilated using Hank and Hegar dilators up to a Hank dilator of 20 and Hagar dilator of 10. The hysteroscope was then inserted and the above findings were noted. A sharp curette was then introduced and the 4 cm polyp was removed. The hysteroscope was then reinserted and the polyp was found to be completely removed at this point. The polyp was sent to Pathology for evaluation. The uterine elevator was then placed as a means to manipulate the uterus. The weighted speculum was removed. Gloves were changed. Attention was turned to the anterior abdominal wall where 1 cm infraumbilical skin incision was made. While tenting up the abdominal wall, the Veress needle was inserted without difficulty. Using a sterile saline drop test, appropriate placement was confirmed. The abdomen was then insufflated with appropriate volume inflow of CO2. The #11 step trocar was placed without difficulty. The above findings were then visualized. A 5 mm port was placed 2 cm above the pubic symphysis. This was done under direct visualization and the

grasper was inserted through this port for better visualization. A 12 mm port was then made in the right lateral aspect of the abdominal wall and the Endo-GIA was inserted through this port and the fallopian tube and ovary were incorporated across the infundibulopelvic ligament. Prior to this, the cyst was aspirated using 60 cc syringe on a needle. Approximately, 20 cc of blood-tinged fluid was obtained. After the ovary and fallopian tube were completely transected, this was placed in an EndoCatch bag and removed through the lateral port site. The incision was found to be hemostatic. The area was suction irrigated. After adequate inspection, the port sites were removed from the patient's abdomen and the abdomen was desufflated. The infraumbilical port site and laparoscope were also removed. The incisions were then repaired with #4-0 undyed Vicryl and dressed with Steri-Strips. 10 cc of 0.25% Marcaine was then injected locally. The patient tolerated the procedure well. The sponge, lap, and needle counts were correct x2. She will be followed up on an outpatient basis.