

PREOPERATIVE DIAGNOSES:,1. Chronic pelvic inflammatory disease.,2. Pelvic adhesions.,3. Pelvic pain.,4. Fibroid uterus.,5. Enterocele.,POSTOPERATIVE

DIAGNOSES:,1. Chronic pelvic inflammatory disease.,2. Pelvic adhesions.,3. Pelvic pain.,4. Fibroid uterus.,5.

Enterocele.,PROCEDURE PERFORMED:,1. Laparoscopic assisted vaginal hysterectomy, bilateral salpingo-oophorectomy.,2. McCall's culdoplasty.,3.

Cystoscopy.,ANESTHESIA: , General

endotracheal.,ESTIMATED BLOOD LOSS: , 350

cc.,INDICATIONS: ,The patient is a 45-year-old Caucasian female with complaints of long standing pelvic pain throughout the menstrual cycle and worse with menstruation, uncontrolled with Anaprox DS also with complaints of dyspareunia. On laparoscopy in May of 2003, PID, adenomyosis, and uterine fibroids were demonstrated. The patient desires definitive treatment.,FINDINGS AT THE TIME

OF SURGERY: ,Uterus was retroverted and somewhat boggy on bimanual examination without any palpable adnexal abnormalities. On laparoscopic examination, the uterus was quite soft and boggy consistent with the uterine adenomyosis. There was also evidence of fibroid change in the right fundal aspect of the uterus. There was a white exudative material covering the uterus as well as bilateral ovaries and fallopian tubes. There were filmy adhesions to the right pelvic side wall, as well as left pelvic side wall.,PROCEDURE: , The patient taken to the operative suite where anesthesia was found to be adequate. She was then prepared and draped in the normal

sterile fashion. A Foley catheter was initially placed and was noted to be draining clear to yellow urine. A weighted speculum was placed in the patient's vagina. The bladder was elevated and the anterior lip of the cervix was grasped with a vulsellum tenaculum. The uterus sounded to 7 cm and the cervix was then progressively dilated. A #20 Hank dilator, which was left within the cervix used in conjunction with the vulsellum tenaculum as a uterine manipulator. At this time, after the gloves were changed, attention was then turned to the patient's abdomen. A small approximately 1 cm infraumbilical incision was made with the scalpel. A Veress needle was then inserted through this incision and a pneumoperitoneum was created with CO<sub>2</sub> gas with appropriate volumes and pressures. A #10 mm step trocar was then inserted through this site and intraabdominal placing was confirmed with the laparoscope. On entrance into the patient's abdomen and pelvis, survey of the abdomen and pelvis revealed the operative area to be relatively free of adhesions except for the right pelvic saddle in which there were filmy adhesions. There was also white exudate noted covering the surface of the uterus and adnexa and the uterus had a quite boggy appearance. At this time, under transillumination in the left anterior axillary line, a second incision was made with a scalpel and through this site a #12 mm step trocar was inserted under direct visualization by the laparoscope. A third incision was made in the right anterior axillary line under transillumination and through this site a second #12 mm step trocar was placed under direct

visualization by the laparoscope. Then 2 cm above the pubic symphysis in the midline and fourth incision was made and a #5 mm step trocar was inserted through this site. The uterus was elevated and deviated to the patient's right and infundibulopelvic ligament on the left was placed on tension with the aid of a grasper. The Endo-GIA was placed through the left sided port and was fired was to cross the infundibulopelvic ligament and down passed to the level of the round ligament, transecting and stapling at the same time. Attention was then turned to the right adnexa.,The uterus was brought over to the patient's left and the right infundibulopelvic ligament was placed on tension with the aid of a grasper. An Endo-GIA was used to transect and staple this vasculature and down passed to the level of round ligament. At this time, there was noted to be a small remnant of the round ligament on the right and a Harmonic scalpel was used to complete the transection and was found to be hemostatic. In addition, on the left the same procedure was performed to completely transect the round ligament on the left and a good hemostasis was noted. At this time, the uterus was dropped and the vesicouterine peritoneum was grasped with graspers. The bladder was then dissected off of the lower uterine segment with the aid of a Harmonic scalpel and hemostasis was appreciated. The anterior cervix of the uterus was scored in the midline up to the level of the fundus with the aid of a Harmonic scalpel and then out to the adnexa bilaterally to aid in orientation during the vaginal portion of the procedure. At this time, copious suction irrigation was performed and the

operative sites were found to be hemostatic. The pneumoperitoneum was evacuated and the attention was then turned to the vaginal portion of the procedure. The weighted speculum was placed into the patient's vagina. At this time, the Foley catheter was noted to have \_\_\_\_\_ and there was noted to be a small puncture site noted into the Foley bulb. The Foley catheter was replaced and the bladder was to be filled at a later time with methylene blue to rule out any bladder injury during the laparoscopic part of the procedure. The cervix was then grasped from right to left with a Lahey clamps and the anterior vaginal mucosa was placed on stretch with aid of Allis clamps. The vaginal mucosa anteriorly was then incised with aid of a scalpel from the 9 o'clock position to 3 o'clock position. The anterior vaginal mucosa and bladder were suctioned and were then dissected away from the lower uterine segment with the aid of Mayo scissors and blunt dissection until anteriorly the peritoneal cavity was entered at which time the peritoneal incision was extended bluntly. Next, using Lahey clamps serially following the \_\_\_\_\_ placed by the Harmonic scalpel from above were followed up to the pubic uterine fundus until the uterus was delivered into the vagina anteriorly. At this time, two curved Heaney clamps were placed across the uterine artery on the right. This was then transected and suture ligated with #0 Vicryl suture. The second clamp was advanced to incorporate the cardinal ligament complex and this was then transected and suture ligated with #0 Vicryl suture. Attention was then turned to the left uterine artery which was again

doubly clamped with curved Heaney clamps, transected and suture ligated with #0 Vicryl suture. This second clamp was then advanced to capture the vasculature and the cardinal ligament complex. This was again transected and suture ligated with #0 Vicryl suture. Next, the uterosacral were clamped off with the curved Heaney clamps and this clamp was met in the midline by another clamp just underneath the cervix and clamping off of the vaginal cuff. Next the uterus, ovaries and cervix were transected away from the vaginal cuff with the aid of double pointed scissors and this specimen was handed off to pathology. At this time, the bladder was instilled with approximately 800 cc of methylene blue and there was no evidence of any leak of blue dye as could be seen from the perspective of the vaginal portion of the procedure. Next, the posterior vaginal cuff and posterior peritoneum were incorporated in a running lock stitch of #0 Chromic beginning at the 9'o clock position over to the 3'o clock position. Next, the anterior vaginal mucosa was grasped with the Allis clamp and the peritoneum was identified anteriorly. The angles of the vaginal cuff were then closed with #0 Chromic suture figure-of-eight stitch with care taken to incorporate the anterior vaginal mucosa, the anterior peritoneum, and the previously closed posterior vaginal mucosa and the posterior peritoneum. Two additional sutures medially were placed and these were tagged and not tied in place. A #0 Vicryl suture on a UR6 needle was used to perform the McCall's culdoplasty type approximation with the vaginal cuff to open and the uterosacral ligament visualized. This was then tied in place

and the remainder of the vaginal cuff was closed with #0 Chromic suture with figure-of-eight stitches. At this time, the gloves were changed and attention was returned to the laparoscopic portion of the procedure at which time the abdomen was re-insufflated and the patient was placed in Trendelenburg. The bowel was moved out of the way and copious suction irrigation was performed and all operative areas were noted to be hemostatic. The bladder was again filled with approximately 400 cc methylene blue and from the laparoscopic \_\_\_\_\_ point there was no evidence of leakage of blue dye at this time. The pneumoperitoneum was then evacuated and a cystoscopy was performed filling the bladder with approximately 400 cc of normal saline and there was noted to be a pinpoint perforation right on bladder dome which was found to be hemostatic and was not found to have any leakage at this time. The bladder was then drained and the Foley catheter was replaced and after gloves changed, attention was turned to the abdomen with the laparoscopic instruments removed from the patient's abdomen. The skin incisions were closed with #4-0 undyed Vicryl in a subcuticular fashion. Approximately 10 cc of 0.25% Marcaine in total were injected at incision site for additional analgesia. The Steri-Strips were placed. The patient tolerated the procedure well and taken to recovery in stable condition. Sponge, lap, and needle counts were correct x2. The specimens include the uterus, cervix, bilateral ovaries, and fallopian tubes. The patient will have her Foley catheter maintained for approximately 7 to 10 days.