PREOPERATIVE DIAGNOSES:,1. Hypermenorrhea.,2. Pelvic pain.,3. Infertility.,POSTOPERATIVE DIAGNOSES:,1. Enlarged fibroid uterus.,2. Infertility.,3. Pelvic pain.,4. Probable bilateral tubal occlusion.,PROCEDURE PERFORMED:,1. Dilatation and curettage.,2. Laparoscopy.,3. Injection of indigo carmine dye.,GROSS FINDINGS: , The uterus was anteverted, firm, enlarged, irregular, and mobile. The cervix is nulliparous without lesions. Adnexal examination was negative for masses.,PROCEDURE: ,The patient was placed in the lithotomy position, properly prepared and draped in sterile manner. After bimanual examination, the cervix was exposed with a weighted vaginal speculum and the anterior lip of the cervix was grasped with vulsellum tenaculum. Uterus sounded to a depth of 10.5 cm. Endocervical canal was progressively dilated with Hanks dilators to #20-French. A medium-sized sharp curet was used to obtain a moderated amount of tissue upon curettage, which was taken from all uterine quadrants and sent to the pathologist for analysis. A _____ syringe was then introduced into the uterine cavity to a depth of 9 cm and the balloon insufflated with 10 cc of air. A 20 cc syringe filled with dilute indigo carmine dye was attached to the end of the _____ syringe to use to inject at the time of laparoscopy.,A small subumbilical incision was then made with insertion of the step dilating sheath with a Veress needle into the peritoneal cavity. The peritoneal cavity was insufflated with 3 liters of carbondioxide and a 12 mm trocar inserted. The laparoscope was then inserted through the trocar with visualization of the pelvic contents. In steep

Trendelenburg position, the uterus was visualized and aided by use of a Bierman needle to displace bowel from visualized areas. The fallopian tubes appeared normal bilaterally with good visualization of a normal appearing fimbria. The ovaries also appeared normal bilaterally. The uterus was greatly enlarged and distorted with large fibroids in multiple areas and especially on the right coronal area. An attempt was made to inject the indigo carmine dye and in fact a three syringes of 20 cc were injected without any visualization of intraperitoneal dye still. Both fallopian tubes apparently were blocked. The upper abdomen was visually explored and found to be normal as was the bowel and area of the right ileum. The patient tolerated the procedure well. Instruments were removed from the vaginal vault and the abdomen. Trocar was removed and the carbondioxide allowed to escape and the subumbilical wound repaired with two #4-0 undyed Vicryl sutures. Sterile dressing was applied to the wound and the patient was sent to the recovery area in satisfactory postoperative condition.