TAH and TAH/BSO

PREOPERATIVE DIAGNOSES: 1. Menorrhagia. 2. Uterine fibroids. 3. Pelvic pain.
POSTOPERATIVE DIAGNOSES: 1. Menorrhagia. 2. Uterine fibroids. 3. Pelvic pain.
PROCEDURE: Exploratory laparotomy, TAH *[bilateral salpingo-oophorectomy]*
SURGEON:
ASSISTANT: ANESTHESIA:
INTRAVENOUS FLUIDS:
ESTIMATED BLOOD LOSS:
URINE OUTPUT: COMPLICATIONS:
SPECIMENS: Uterus and cervix *[right ovary and tube, left ovary and tube]*
DISPOSITION: Stable to recovery room
INDICATIONS:
FINDINGS: Exam under anesthesia revealed an enlarged, irregularly shaped 20 week sized uterus with limited mobility. Multiple uterine fibroids, ranging from 1 cm to 6 cm in size. Both tubes and ovaries appeared to be grossly normal. There were thin, filmy adhesions on the posterior aspect of the uterus.

PROCEDURE: The patient was taken to the OR where general anesthesia was administered. She was prepped and draped in normal sterile fashion and placed in dorsal lithotomy position. A Foley catheter was placed. A pfannensteil skin incision was made with the scalpel and carried through the underlying layer of the fascia using the Bovie. The fascia was incised in the midline with the scapel and this incision was extended laterally using the mayo scissors. The rectus muscles were dissected away from the fascia. The peritoneum was identified, tented up and entered in sharply with Metzenbaum scissors. The peritoneal incision was extended both superiorly and
inferiorly. The uterus was delivered to the incision.

Two Kelly clamps were used to grasp the cornua of the uterus. The round ligament was identified, suture ligated with #0 Vicryl and transected using the Bovie. The anterior and posterior leaves of the broad ligament were opened and the bladder flap was created using the Bovie. The utero- ovarian ligaments were identified on both sides, clamped, transected and ligated with a free tie. At this time, the uterine arteries were skeletonized bilaterally. The uterine arteries were clamped, transected and suture ligated. Serially, the uterosacral and cardinal ligaments were clamped, transected using Mayo scissors and suture ligated. Two Heaney clamps were placed at the base of the cervix, and the cervix and uterus were amputated from the vagina. The vaginal cuff angles were ligated using #0 Vicryl. The remainder of the vaginal cuff was reapproximated using an interrupted, figure-of-eight #0 Vicryl suture.

[*At this time, attention was turned to bilateral ovaries which were grasped with Babcock clamps. The IP ligaments were grasped and clamped with Heaney clamps, the ovary and tube were transected. The IP ligaments on both sides were ligated with a free tie and suture ligated with a #0 Vicryl.*]

The pelvis and abdomen were irrigated with normal saline. There was one small area of bleeding on the right aspect of the vaginal cuff that became hemostatic using a 2-0 Vicryl in a running, locked fashion. Inspection of all pedicles again revealed hemostasis. All instruments and laparotomy sponges were removed from the patient's abdomen.

The fascia was reapproximated using a #0 vicryl in a running fashion. The subcutaneous tissue was reapproximated using 2-0 plain gut in interrupted fashion. The skin was closed with staples. The patient tolerated the procedure well. Sponge, lap, needle and instrument counts were correct x2. The patient was taken to the recovery room in stable condition.

Dr. ____was present and scrubbed for the entire case.