Anterior colporrhaphy and Cystourethroscopy.

PREOPERATIVE DIAGNOSIS:
Stage II cystocele.
POSTOPERATIVE DIAGNOSIS:
Stage II cystocele.
PROCEDURE:
Anterior colporrhaphy and cystourethroscopy.
SURGEON:
ASSISTANTS:
ANESTHESIA:
GETA and local with 0.25% bupivacaine with epinephrine.
ESTIMATED BLOOD LOSS:
URINE OUTPUT:
SPECIMENS:
DRAINS:
Transurethral Foley catheter.
COMPLICATIONS:
CONDITION:
Stable to PACU.

INDICATIONS:
This is a 73-year-old female with stage II anterior vaginal prolapse who desires definitive surgical therapy with anterior colporrhaphy and cystourethroscopy. Preoperatively risks, benefits and alternatives were discussed with the patient and she verbalized understanding and elected to proceed with surgery and written consent was obtained for the above noted procedure.

FINDINGS:
Exam under anesthesia revealed stage II cystocele with good apical and posterior support. Exam performed at the end of the procedure revealed excellent reduction of the anterior prolapse with adequate vaginal caliber and no undue tension. Cystourethroscopy performed at the end of the procedure revealed no evidence of bladder injury or sutures visible within the bladder. Bilateral ureteral orifices were visualized with spill noted from each side and otherwise no masses or lesions noted within the bladder.

PROCEDURE:
The patient was taken to the OR where anesthesia was administered. She was prepped and draped in the normal sterile fashion in the dorsal lithotomy position in the Allen stirrups. Care was taken upon positioning to avoid any areas of extreme flexion or extension. A transurethral Foley catheter was placed and the bladder was drained. The Lone Star retractor was placed with the hooks at the level of the hymenal ring.
Attention was turned to the vaginal epithelium which was injected with 0.25% bupivacaine with epinephrine. A vertical midline incision was made with the scalpel from the level of the bladder neck to 1 cm distal to the cervix. The underlying fibromuscular tissue was dissected away from the vaginal epithelium and the cystocele was exposed. The dissection bed was inspected and excellent hemostasis was noted. Dissection was performed to the level of the pubic rami bilaterally. The cystocele was reduced with 2-0 Maxon vertical mattress stitches in 1 layer. The excess vaginal epithelium was trimmed and the vaginal epithelium was closed with 0 Vicryl in interrupted stitches.
The transurethral Foley catheter was removed and a 17-French, 70 degree cystoscope was inserted through the urethra into the bladder with the above noted findings. The cystoscope was removed. The Foley catheter was replaced and the bladder was drained.
Sponge, lap and needle counts were correct x2. All remaining instruments were removed from the vagina. The patient tolerated the procedure well. She was taken out of the dorsal lithotomy position and was then awakened from anesthesia. She was transferred to the recovery room awake, alert and breathing independently in stable condition. A transurethral Foley catheter remained in place at the end of the procedure for a postoperative voiding trial.

Dr. Amundsen was scrubbed, present and participated throughout the entire procedure.