Robotic Assisted TLH/BSO

MRN:
NAME:
Date of Procedure:
DOB:
Attending:
Dictating:
PREOPERATIVE DIAGNOSES:
1. Large adnexal mass and elevated CA-125.
2. Fibroid uterus.
POSTOPERATIVE DIAGNOSES:
1. Endometriosis.
2. Large adnexal mass and elevated CA-125.
3. Fibroid uterus.
PROCEDURES:
Robotic-assisted total laparoscopic hysterectomy, bilateral salpingo-oophorectomy, ureterolysis and pelvic washings.
SURGEON:
FIRST ASSISTANT:
SECOND ASSISTANT:
ANESTHESIA:
ESTIMATED BLOOD LOSS:
COMPLICATIONS:
FINDINGS:
On laparoscopic examination, the patient had a normal-sized uterus. The bilateral tubes and ovaries contained cystic masses containing motor oil type fluid. There are some filmy adhesions involving the cystic masses and the left pelvic side wall. The left ureter was tethered up with the infundibulopelvic ligament and the posterior aspect of the cystic mass. There is no evidence of any tumor spread outside of the pelvis. There was no free fluid or ascites and the remainder of the pelvic and abdominal survey was within normal limits. Frozen section revealed a hemorrhagic cyst and possible endometriosis.

PROCEDURE IN DETAIL:
The patient was taken to the operating room where general endotracheal anesthesia was induced and found to be adequate. She was then placed in the dorsal lithotomy position and her arms were carefully tucked at her sides. She was prepped and draped in the normal sterile fashion. A Foley catheter was placed in the bladder and the standard VCare uterine manipulator was placed in the uterus. A 12-mm balloon trocar was placed above the umbilicus using the open technique. Robotic laparoscope was placed to confirm correct placement of the trocar. The abdomen was insufflated with CO2 gas to a pressure of 15 mmHg. Pelvic and abdominal surveys were performed with the findings noted above. Bilateral 8 mm robotic ports, a right lower quadrant 8 mm robotic port and a left upper quadrant 5/12 mm assistant port were placed under direct visualization with the laparoscope. The patient was placed into the Trendelenburg position and the bowel was displaced into the upper abdomen. Robot was then docked on the patient's right side.

Cytologic washings were obtained and sent for pathology. The bilateral round ligaments were then cauterized and divided. Retroperitoneal space was opened for adequate identification of the infundibulopelvic ligaments and ureters. On the left side, the ureter was tethered up within the infundibulopelvic pedicle as well as to the posterior aspect of the cystic mass and therefore ureterolysis was performed with blunt and sharp dissection with electrocautery used where needed. The bilateral infundibulopelvic ligaments were then skeletonized, cauterized and divided using the robotic instruments with care taken to preserve the ureter. Bladder flap was then created taking her bladder down off the lower uterine segment and cervix. The bilateral uterine arteries were then skeletonized, cauterized and divided down to the level of the cervicovaginal junction. Colpotomy incision was made using the electrocautery around the VCare uterine manipulator. Once the cervix was amputated, the uterus and cervix were delivered through the vagina. The right tube and ovary were then removed separately. An Endo Catch bag was then placed into the abdomen and the left tube and ovary were removed through the vagina with no intra-abdominal spillage of cystic contents. A pneumo balloon was then placed into the vagina in order to maintain pneumoperitoneum. The vaginal cuff was then closed with a running

continuous stitch of 0 V-lock suture with care taken to include the vaginal cuff angles and the vaginal mucosa within the closure. Frozen pathology revealed no evidence of malignancy.

The pelvis was then irrigated. The vaginal cuff, all of the vascular pedicles and dissection sites were found to be hemostatic. Hemostasis was maintained when intraperitoneal pressure was decreased. The robot was then undocked. The left upper quadrant port was removed through the fascia. That port site was closed with 0 Polysorb utilizing the Endoclose technique. The ports were then removed and the CO2 gas allowed to escape from the abdomen. The fascia at the umbilical port site was closed with figure-of-eight stitch of 0 Polysorb. The subcutaneous tissue at all 5 port sites was irrigated and the skin was closed with a subcuticular stitch of 4-0 Monocryl and Indermil glue.

The patient tolerated the procedure well. Sponge, lap, needle and instrument counts were correct x2 at the end of the procedure.

Dr. _____ was present and actively participated throughout the case.