Anterior and Posterior Colporrhaphy

MRN:
NAME:
Date of Procedure:
DOB:
Operative Report
SURGEON:
ASSISTANT:
PREOPERATIVE DIAGNOSIS:
A 52-year-old female with stress urinary incontinence stage 2 cystocele and stage 2 rectocele.
POSTOPERATIVE DIAGNOSIS:
A 52-year-old female with stress urinary incontinence stage 2 cystocele and stage 2 rectocele.
PROCEDURE:
Bard mid-urethral sling, cystourethroscopy, anterior colporrhaphy, posterior colporrhaphy.
ANESTHESIA:
IV FLUIDS:
ESTIMATED BLOOD LOSS:
URINE OUTPUT:
COMPLICATIONS:
DRAINS:
SPECIMENS:
FINDINGS:
1. Normal cystourethroscopy at the completion of the anterior colporrhaphy and after passage of both sling trocars. There was no evidence of injury to the bladder or urethra. No evidence of injury of the trocars into the bladder or urethra. Good bilateral ureteral jets of indigo carmine-stained urine were noted.
2. Good hemostasis at the completion of the procedure.
3. Sponge, needle and instrument counts correct.
4. Normal rectal exam at the completion of posterior repair with no evidence of injury to the rectum and no suture material in the rectum.
5. Bilateral fornices inspected and found to be without evidence of injury.

DESCRIPTION OF PROCEDURE:
The patient was consented for a mid-urethral sling, anterior repair, posterior repair and cystourethroscopy. She was given perioperative IV antibiotics and taken to the OR where she underwent general anesthesia without difficulty. She was prepped and draped in the usual sterile fashion in the dorsal lithotomy position with Allen stirrups. Care was paid to positioning lower extremities in the Allen stirrups to ensure no extreme flexion or extension of the lower extremities. A Foley catheter was placed. A Lone Star retractor was placed.

The vaginal mucosa overlying the anterior vaginal wall was grasped with Allis clamps and injected with local anesthetic with epinephrine. A vertical midline incision was made in the vaginal mucosa overlying the patient's cystocele. The vaginal mucosa was dissected away from the underlying fibromuscular tissue bilaterally. The fibromuscular tissue was then plicated in the midline with 2-0 Maxon suture. Using the Bovie, achieved excellent hemostasis. Excess vaginal mucosa was trimmed. The vaginal mucosal incision was then closed in an interrupted fashion with 3-0 Vicryl suture.

The vaginal mucosa overlying the midurethra was grasped with Allis clamps and injected with local anesthetic with epinephrine. A vertical midline incision of approximately 1.5 cm was made with a knife in the mucosa over the midurethra. The underlying periurethral connective tissue was dissected away and tunnels were created bilaterally up to the pubic ramus. A Bard mid-urethral sling trocar was introduced into the tunnel on the patient's right, it was passed into the space of Retzius through the rectus fascia and out through a stab incision on the mons pubis. A Bard trocar was then introduced into the tunnel on the patient's left, passed into the space of Retzius through the rectus fascia and out through a stab incision on the mons pubis. The Foley catheter was removed and cystoscopy was performed that demonstrated no evidence of injury of the trocar into the bladder or urethra, and no evidence of injury to the bladder or urethra, and

ultimately good bilateral ureteral jets of indigo carmine were seen. The cystoscope was removed and a Foley catheter was placed. The sling material was attached to the trocars and advanced up through the stab incisions on the mons pubis. Sling material was then positioned in a tension-free fashion over the midurethra. Plastic sheath over the sling material was removed and again position in a tension-free fashion over the midurethra was confirmed. Due to oozing, 5 cc of FloSeal were injected into the dissection space and tunnels bilaterally. After pressure was held, good hemostasis was achieved. The excess sling material was trimmed at the mons and these incisions were closed with skin glue. The vaginal mucosal incision was closed in an interrupted fashion with 3-0 Vicryl suture.

The posterior vaginal wall was grasped with Allis clamps and injected with a local anesthetic. A rectal exam was done to confirm the extent of the patient's rectocele. A vertical midline incision was made with a knife in the vaginal mucosa overlying her rectocele. The vaginal mucosa was dissected away from the underlying fibromuscular tissue bilaterally. The fibromuscular tissue was then plicated in the midline using 2-0 Maxon suture with intermittent rectal and vaginal exams to ensure no entry of suture material into the rectum and no tension or tether points created in the vagina. The dissection space was made hemostatic by use of the Bovie. Excess vaginal mucosa was then trimmed. The mucosal incision was closed in an interrupted fashion with 3-0 Vicryl suture. Due to a small degree of oozing that persisted in the dissection space, the patient was packed with Kerlix, with the plan for removal of the packing prior to void trial.

All instruments were otherwise removed from the patient's vagina. She was awakened, LMA removed and taken to the recovery room in stable condition. Sponge, needle and instrument counts were correct.

Dr. _____ was present and involved in all aspects of the procedure.