Total Laparoscopic Hysterectomy

PREOPERATIVE DIAGNOSIS: Dysmenorrhea and pelvic pain.
POSTOPERATIVE DIAGNOSIS: Dysmenorrhea and pelvic pain.
SURGEON:
ASSISTANT:
ANESTHESIA:
INTRAVENOUS FLUIDS:
ESTIMATED BLOOD LOSS:
URINE OUTPUT:
COMPLICATIONS:
SPECIMENS: Uterus and cervix
DISPOSITION: Stable to recovery room
INDICATIONS:
FINDINGS: Exam under anesthesia revealed uterus approximately 6 to 8 weeks in size. On laparoscopy, pelvic anatomy is grossly normal. No evidence of endometriosis or adhesive disease. Ovaries appeared grossly normal. Minimal adhesions noted on the right pelvic side wall into the abdominal gutter involving the appendix. Grossly normal liver, appendix and gallbladder.

PROCEDURE: The patient was taken to the OR where general anesthesia was administered. She was prepped and draped in normal sterile fashion in the dorsal lithotomy position in the Allen stirrups. A speculum was placed in the vagina, the anterior lip of the cervix was grasped with the single tooth tenaculum. The RUMI uterine manipulator with the small sized blue cup was placed. Gloves were changed and attention was turned to the abdomen. 0.25% Marcaine was injected locally into the the umbilical fold and a 5mm skin incision was made with the scalpel. A Veress step needle was introduced into the abdomen while elevating the skin. Intraabdominal placement was confirmed using the saline syringe. The CO2 gas was applied. Opening intra-abdominal pressure was noted to be 2mmHg. Once the pneumoperitoneum was obtained, the 5 mm trocar was placed through the step. The laparoscope was then introduced and a survey of the pelvic cavity revealed the above noted findings. The laparoscope was then used to locate the external iliac vessels and the round ligament and then the inferior epigastric artery.

Attention was turned to the RLQ where 0.25% Marcaine was injected locally. A 1cm skin incision was made with the scalpel and the Veress step needle and trocar were introduced under direct visualization. The Endo Shears were used to take down the adhesions on the right pelvic side wall. A third port was placed under direct visualization in the left lower quadrant by the same method.

The grasper was then used to elevate the round ligament and the 10 mm LigaSure cauterized the round and the utero-ovarian ligaments on the left side. The broad ligament was then cauterized and cut using the LigaSure to open up the anterior and posterior leaves, which were further dissected with the Endo Shears. A similar procedure was repeated on the right side to take down the round and the ovarian ligaments. The Endo Shears were used to skeletonize the uterine arteries bilaterally and the uterin arteries were then cauterized at the level of the cervix and vagina where the blue cup could be palpated with the 10 mm LigaSure. The Endo Shears were then used to make a colpotomy circumferentially at cervix where the blue cup could be palpated with first coag and then cut. The specimen was then amputated.

The uterus and cervix were retracted in the vagina using the RUMI device. The angles were suture ligated with 0 Vicryl bilaterally using the EndoStitch. A figure-of-8 was placed in the center of the vaginal cuff with extracorporeal knot tying. The pelvis was irrigated and cleared of all clots and debris. Excellent hemostasis was noted. The 10 mm trocars were removed under direct visualization. The 5 mm umbilical trocar was then removed. The skin incisions were closed with Indermil. Sponge, lap, and needle counts were correct x2. The patient was taken to the recovery room in stable condition.

Dr. ____was present and scrubbed for the entire case.