

Obstetrics

Dilation and Evacuation

PREOPERATIVE DIAGNOSIS: Intrauterine fetal demise at 16 weeks 3 days.

POSTOPERATIVE DIAGNOSIS: Intrauterine fetal demise at 16 weeks 3 days.

PROCEDURE: Dilation, evacuation and curettage.

SURGEON: ASSISTANT: ANESTHESIA: INTRAVENOUS FLUIDS:

ESTIMATED BLOOD LOSS:

URINE OUTPUT: COMPLICATIONS:

SPECIMENS: Products of conception.

DISPOSITION: Stable to recovery room

FINDINGS: Exam under anesthesia revealed 16 week size uterus. Normal endometrial stripe was noted on ultrasound at the end of the procedure. Prior to sending the specimen to pathology, the four extremities, calvarium and thorax were identified in the products of conception.

DESCRIPTION OF PROCEDURE:

The patient was taken to the operating room where general anesthesia was administered. She was then prepped and draped in the dorsal lithotomy position in candy cane stirrups in a sterile fashion. Five laminaria dilators were removed from the cervix as well as two 4 x 4 gauze, both of which had been placed the day prior to surgery for cervical dilation.

The speculum was placed in the vagina, the anterior lip of the cervix was grasped with a single tooth tenaculum. Under ultrasound guidance, a #10 suction cannula was used to puncture the amniotic membrane and drain amniotic fluid. Large Sopher forceps were then used to remove the intrauterine contents until the uterine cavity was emptied. Gentle curettage was performed to gritty texture and then suction was performed to complete the procedure with confirmation of a normal endometrial stripe on ultrasound as noted above.

At this time moderate bleeding was noted so the patient was given 0.2mg intravenous Methergine with subsequent decrease in bleeding.

The speculum, tenaculum and all other instrumentation were then removed from the patient's vagina. All sponge, lap, needle counts were correct x2. The patient tolerated the procedure well and was transferred to the recovery room awake, alert and breathing independently in stable condition.

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

Post Partum BTL

PREOPERATIVE DIAGNOSIS: Multiparous patient, desiring permanent sterilization.

POSTOPERATIVE DIAGNOSIS: Multiparous patient, desiring permanent sterilization.

OPERATION: Bilateral tubal ligation (via modified Parkland/modified Pomeroy, etc.)

SURGEON:

ASSISTANT:

ANESTHESIA:

INTRAVENOUS FLUIDS:

ESTIMATED BLOOD LOSS:

URINE OUTPUT:

COMPLICATIONS:

SPECIMENS: Portion of Left Fallopian tube, portion of Right Fallopian tube

DISPOSITION: Stable to recovery room

FINDINGS: Normal uterus, tubes and ovaries bilaterally. No intraabdominal adhesions noted.

DESCRIPTION OF PROCEDURE:

The patient was taken to the operating room where anesthesia was administered. The patient was then prepped and draped in the normal sterile fashion in the dorsal supine position. Spinal anesthesia was found to be adequate and a small longitudinal incision at the inferior aspect of the umbilicus was made with the scalpel. This incision was carried down to the fascia and peritoneum with a combination of blunt and sharp dissection. The peritoneum was then entered and upon entry into the abdomen no adhesions were noted.

The left Fallopian tube was identified, grasped with the Babcock clamps, lifted to the skin incision and followed out distally to the fimbriae. An avascular midsection of the tube approximately 3-4cm from the cornua was grasped with the babcock clamps and brought into a knuckle at the skin incision. The tube was double ligated with 0 plain gut suture and the intervening portion of tube was transected and removed. Excellent hemostasis was noted and the tube was returned to the abdomen. Attention was then turned to the right fallopian tube after confirmation of identification by tracing the tube out to the fimbriae. The same procedure was then performed on the right Fallopian tube. Again, excellent hemostasis was noted at the end of the procedure.

The fascia was then closed with 2-0 Vicryl in a single laye and the skin was closed with 4-0

Monocryl in a subcuticular fashion. The patient tolerated the procedure well. All counts were correct times two. The patient was taken to the recovery room in stable condition.

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

McDonald Cerclage

PREOPERATIVE DIAGNOSIS: History of cervical incontinence, intrauterine pregnancy at 13 weeks.

POSTOPERATIVE DIAGNOSIS: History of cervical incontinence, intrauterine pregnancy at 13 weeks.

PROCEDURE: Prophylactic McDonald cerclage.

SURGEON:

ASSISTANT:

ANESTHESIA:

INTRAVENOUS FLUIDS:

ESTIMATED BLOOD LOSS:

URINE OUTPUT:

COMPLICATIONS:

SPECIMENS: None

DISPOSITION: Stable to recovery room

FINDINGS: Cervix was noted to be 1cm dilated at beginning of procedure and was closed at the end of the procedure. No amniotic fluid or pooling was noted at any time during the procedure.

PROCEDURE IN DETAIL:

The patient was taken to the operating room where spinal anesthesia was administered. She was then prepped and draped in a normal sterile fashion in the dorsal lithotomy position in the candy cane stirrups.

A weighted speculum was placed in the vagina with good visualization of the cervix. The cervix was clamped both anteriorly and posteriorly with ringed forceps in a clockwise fashion and stitches of Mersilene 5 mm tape were placed at 11 o'clock, 9 o'clock, 5 o'clock and 1 o'clock. The stitch was then tied using square knots at 12 o'clock. At this point the cervix was found to be closed. Excellent hemostasis was noted and all instruments were removed from the vagina.

The patient tolerated the procedure well. All sponge, lap and needle counts were correct x2. The patient was taken to the recovery room in good condition.

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

Cesarean Section

PREOPERATIVE DIAGNOSES: IUP at 38 weeks 4 days with nonreassuring fetal heart tracing

POSTOPERATIVE DIAGNOSES: IUP at 38 weeks 4 days with nonreassuring fetal heart tracing

PROCEDURE: Primary low transverse cesarean section via pfannensteil skin incision with double layer uterine closure

SURGEON:

ASSISTANT:

ANESTHESIA:

INTRAVENOUS FLUIDS:

ESTIMATED BLOOD LOSS:

URINE OUTPUT:

COMPLICATIONS:

SPECIMENS:

DISPOSITION: Stable to recovery room

INDICATIONS:

FINDINGS: No intraabdominal adhesions were noted. Female infant in cephalic presentation with loose nuchal cord x 2 and clear amniotic fluid. Birth weight 3495g. Apgars of 8 and 9. Intact placenta with a three-vessel cord. Grossly normal uterus, tubes and ovaries bilaterally.

DESCRIPTION OF PROCEDURE:

The patient was taken to the operating room where anesthesia was administered. She was then prepped and draped in the normal fashion in the dorsal supine position with a leftward tilt. A pfannensteil skin incision was made with the scalpel and carried through to the underlying layer of fascia. The fascia was then incised at the midline and this incision was extended laterally with the mayo scissors. Attention was turned to the superior aspect of the fascial incision which was grasped with the kocher clamps x 2, tented up and the rectus muscles were dissected off with the mayo scissors. In a similar fashion the inferior aspect of the fascial incision was grasped with the kocher clamps, tented up and the rectus muscles dissected off with the mayo scissors. The rectus muscles were then separated in the midline and the peritoneum was entered bluntly. The bladder blade was inserted and the vesicouterine peritoneum was identified, tented up and entered with the metzenbaum scissors. This incision was extended laterally and the bladder flap was created digitally. The bladder blade was reinserted.

A low transverse hysterotomy was made with the scalpel until the endometrial cavity was breached yielding clear amniotic fluid. This incision was extended bluntly and the infant's head was delivered atraumatically. The nose and mouth were bulb suctioned and the nuchal cord x 2 was easily reduced. The remainder of the body was delivered atraumatically. The cord was clamped x 2 and cut, and the infant was handed to the awaiting pediatricians.

The placenta was then manually extracted and the uterus was exteriorized and cleared of all clots and debris. The hysterotomy was repaired with a running suture of 1-0 chromic. A second imbricating layer of 1-0 chromic suture was then placed. Several figure-of-eight sutures of 1-0 chromic were added to achieve excellent hemostasis. The uterus and adnexa were then returned to the abdomen. The hysterotomy was reinspected and excellent hemostasis was noted. The fascia was reapproximated with 0 Vicryl in a simple running fashion. The subcutaneous layer was then reapproximated with interrupted sutures of 2-0 plain gut. The skin was then closed with 4-0 monocryl.

The patient tolerated the procedure well. Sponge, lap, needle, and instrument counts were correct x

2. The patient was transferred to the recovery room awake, alert and breathing independently in stable condition.

Dr. ____ was present throughout the entire procedure.

Gynecology

LEEP

PREOPERATIVE DIAGNOSIS: Cervical intraepithelial neoplasia II.

POSTOPERATIVE DIAGNOSIS: Cervical intraepithelial neoplasia II.

PROCEDURES: Colposcopy, loop electrosurgical excision procedure (LEEP), endocervical curettage.

SURGEON:

ASSISTANT:

ANESTHESIA:

ESTIMATED BLOOD LOSS:

INTRAOPERATIVE FLUIDS:

URINE OUTPUT:

SPECIMENS: LEEP cone biopsy, Endocervical curettings.

DRAINS:

COMPLICATIONS:

DISPOSITION: Stable to PACU.

FINDINGS: Findings on colposcopy: acetowhite epithelium was noted at 3 o'clock and 9 o'clock on the anterior lip of the cervix, both lesions extending into the endocervical canal. Colposcopy was inadequate.

DESCRIPTION OF PROCEDURE:

After informed consent was obtained, the patient was taken to the operating room where general mask anesthesia was obtained without difficulty. The patient was positioned in the dorsal lithotomy position with Allen stirrups. The covered speculum and covered vaginal wall retractor were inserted into the patient's vagina. The cervix was washed with 3% acetic acid solution and examined under colposcopy with the above noted findings. The cervix was grasped with a covered single-tooth tenaculum and 10 mL of 1% lidocaine with epinephrine was injected circumferentially into the cervical bed. A cervical cone biopsy was obtained using a medium extended Fisher exciser on 70- watt pure-cut mode. Endocervical curettage was then performed. The remaining cervical bed was cauterized using ball cautery at 80 watts in coagulation mode. The cervical bed was then inspected and excellent hemostasis was noted.

All instruments were removed from the vagina. The tenaculum site was hemostatic. The patient tolerated the procedure well. All instrument, lap and sponge counts were correct x2 at the end of the procedure. The patient was taken out of the lithotomy position and transferred to the recovery room in stable condition.

Dr. ____ was present throughout the entire procedure.

Cold Knife Conization

PREOPERATIVE DIAGNOSIS: Atypical glandular cell Pap smear.

POSTOPERATIVE DIAGNOSIS: Atypical glandular cell Pap smear.

PROCEDURE: Cervical cold knife cone biopsy with endocervical curetting.

SURGEON:

ASSISTANT:

ANESTHESIA:

INTRAVENOUS FLUIDS:

ESTIMATED BLOOD LOSS:

URINE OUTPUT:

COMPLICATIONS:

SPECIMENS: Cervical cone biopsy

DISPOSITION: Stable to recovery room

FINDINGS: Exam under anesthesia revealed a normal size, mobile uterus with no abnormal masses and the cervix appeared multiparous with no visible lesions.

PROCEDURE:

The patient was taken to the operating room where anesthesia was administered. She was placed in the dorsal lithotomy position and prepped and draped in the normal sterile fashion with candy- cane stirrups. The bladder was emptied of _____cc clear urine via an in and out catheterization at the start of the procedure. The weighted speculum was placed into the vagina and the anterior lip of the cervix was grasped with a single-tooth tenaculum. A paracervical block was placed with 10cc of 1% lidocaine 5 mL each at 4 and 8 o'clock. Stay sutures were then placed at 3 and 9 o'clock with figure-of-eight sutures of #1 chromic.

A cone biopsy was then performed using an 11 blade at the edges of the cervix to remove the entire transformation zone and part of the endocervical canal. After the entire circumference was incised with the scalpel, an Allis clamp was placed on the specimen and the endocervical margin was obtained with Metzenbaum scissors. The specimen was removed and a stitch placed at 12 o'clock for orientation.

Hemostasis of the cone bed was then obtained with electrocautery. Excellent hemostasis was assured at the end of the case and a vaginal pack was placed. All instruments were removed from the vagina. 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 and vaginal pack was removed in one hour with no complications.

Dr. ____ was present and scrubbed for the entire case.

Essure

PREOPERATIVE DIAGNOSIS: Desires permanent sterilization.

POSTOPERATIVE DIAGNOSIS: Desires permanent sterilization.

PROCEDURE: Hysteroscopic bilateral occlusion of fallopian tubes with Essure devices.

SURGEON:

ASSISTANT:

ANESTHESIA:

ESTIMATED BLOOD LOSS:

FLUIDS:

URINE OUTPUT:

SPECIMENS:

DRAINS: In-and-out foley catheter.

COMPLICATIONS: None.

DISPOSITION: Stable to the PACU.

FINDINGS: Exam under anesthesia revealed small mobile anteverted uterus with no masses and bilateral adnexa without masses or fullness. Hysteroscopy revealed a grossly normal appearing uterine cavity.

DESCRIPTION OF PROCEDURE:

The patient was taken to the operating room where anesthesia was administered. She was then placed in the dorsal lithotomy position with the Allen stirrups. The patient was examined under anesthesia with the above noted findings. The perineum and vagina were then prepped and draped in the usual sterile fashion for a vaginal procedure. The patient's bladder was catheterized with an in-and-out red rubber catheter.

The side-arm Graves speculum was then placed inside the patient's vagina and the anterior lip of the cervix was grasped with a single-tooth tenaculum. A paracervical block was achieved by injecting 20 mL of 0.5% ropivacaine, 10 mL on each side at the area of the uterosacral ligaments. The uterus was then sounded to 8 cm. The cervix was progressively dilated up to a size 23 French with Pratt dilators. The diagnostic hysteroscope was advanced inside the patient's uterine cavity with ease and the above findings were noted.

Bilateral fallopian tube ostia were visualized. Attention was turned to the left fallopian tube and the Essure device was placed in the os. After discharge from the cartridge, the Essure placement was noted to be adequate, with ___ coils protruding from the os. Attention was then turned to the right fallopian tube os. The Essure device was placed into the os, and after discharge from the cartridge, Essure placement was noted to be adequate with ___ coils protruding from the os.

The hysteroscope was then removed from the uterus. The uterus and cervix were noted to be hemostatic. The tenaculum was removed from the cervix and tenaculum site was noted to be hemostatic. The speculum and any other instrumentation was then removed from the patient's vagina. The patient was taken out of the lithotomy position and then emerged from anesthesia without complication. The patient tolerated the procedure well and was transferred to the recovery room in stable condition. Instrument, lap, sponge, and sharp counts were correct x2 at the end of the procedure.

Dr. ___ was present and scrubbed for the entire case.

Hydrothermal Ablation

PREOPERATIVE DIAGNOSIS: Fibroids and menorrhagia.

POSTOPERATIVE DIAGNOSIS: Fibroids and menorrhagia.

PROCEDURE: Hysteroscopy and hydrothermal ablation.

SURGEON:

ASSISTANT:

ANESTHESIA:

ESTIMATED BLOOD LOSS:

FLUIDS:

URINE OUTPUT:

SPECIMENS:

DRAINS: In-and-out foley catheter.

COMPLICATIONS: None.

DISPOSITION: Stable to the PACU

FINDINGS: Exam under anesthesia revealed 8 week sized anteverted mobile uterus, no adnexal masses palpated. The uterus was sounded to 9cm. Hysteroscopy revealed atrophic appearing endometrium, bilateral ostia appeared patent with uniform ablation noted at end of procedure.

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. The bladder was drained via in and out catheter. The bivalved speculum was placed in the vagina and a single-toothed tenaculum was used to grasp the anterior lip of the cervix. The cervix was then circumferentially injected with 1% lidocaine using a total of 10cc. The uterus was sounded to 9cm and was serially dilated with the Hagar dilators up to a size 21 French. The hysteroscope was introduced into the uterine cavity with findings as noted above. The Hydrothermal ablation apparatus was activated to 87 degrees Celsius for a total of 10 minutes in the usual fashion under direct visualization. Once the procedure was completed a 1-minute cool-down period was allowed. All instruments were then removed with excellent hemostasis noted.

Sponge lap and needle counts were correct x 2. The patient tolerated the procedure well and was transferred to the recovery room in stable condition.

Dr. ____ was present and scrubbed for the entire case.

Hysteroscopy Dilation and Curettage

PREOPERATIVE DIAGNOSIS: Dysfunctional uterine bleeding with suspected endometrial polyp.

POSTOPERATIVE DIAGNOSIS: Dysfunctional uterine bleeding with suspected endometrial polyp.

OPERATION: Hysteroscopy, polypectomy, dilation and curettage.

SURGEON:

ASSISTANT:

ANESTHESIA:

INTRAVENOUS FLUIDS:

ESTIMATED BLOOD LOSS:

URINE OUTPUT: COMPLICATIONS:

SPECIMENS: Endometrial Curettings

DISPOSITION: Stable to recovery room

FINDINGS: Exam under anesthesia revealed a small anteverted mobile uterus with no adnexal masses or fullness. The uterine cavity was sounded to 9 cm. Hysteroscopy revealed the uterine cavity contained a large, smooth-walled endometrial polyp at the fundus, otherwise the cavity appeared grossly normal

DESCRIPTION OF PROCEDURE:

The patient was taken to the operating room where she was placed under anesthesia. She was prepped and draped in the normal sterile fashion in the dorsal lithotomy position in the Allen stirrups. The patient's bladder was catheterized with an in and out Foley catheter. The patient was examined under anesthesia, and the above findings were noted. The bi-valved speculum was placed inside the patient's vagina. The anterior lip of the cervix was visualized and grasped with a single-toothed tenaculum. A paracervical block was achieved by injecting 10cc of 1% Lidocaine. The uterine cavity was sounded to 9 cm. The cervix was then progressively dilated up to a size 19-French Pratt dilator. The diagnostic hysteroscope was introduced into the uterine cavity and the above findings were noted.

The hysteroscope was removed and the uterine cavity was until a gritty texture was noted yielding moderate endometrial curettings and a large 2-cm x 1-cm tissue mass which appeared to be an endometrial polyp. Excellent hemostasis was noted. The speculum and all other instruments were removed from the patient's vagina. The patient was taken out of the lithotomy position. The patient tolerated the procedure well and was transferred to the recovery room in stable condition.

Dr. ____ was present and scrubbed for the entire case.

Suction Dilation and Curettage

PREOPERATIVE DIAGNOSIS: Missed abortion at 8 weeks

POSTOPERATIVE DIAGNOSIS: Missed abortion at 8 weeks

OPERATION: Suction dilation and curettage.

SURGEON:

ASSISTANT:

ANESTHESIA:

INTRAVENOUS FLUIDS:

ESTIMATED BLOOD LOSS:

URINE OUTPUT:

COMPLICATIONS:

SPECIMENS: POCs

DISPOSITION: Stable to recovery room

FINDINGS: Exam under anesthesia revealed 8 week sized anteverted mobile nontender uterus, no adnexal masses palpated. Uterus sounded to 9cm. Moderate amounts of POCs evacuated.

DESCRIPTION OF PROCEDURE:

The patient was taken to the OR where anesthesia was administered. The patient was prepped and draped in the normal sterile fashion in the dorsal lithotomy position in the Allen stirrups. A bivalved speculum was placed in the patient's vagina and the anterior lip of the cervix was grasped with a single-tooth tenaculum. The patient's cervix was dilated to #29 French with Pratt dilators. A size 8mm suction catheter was advanced into the uterus. The contents of the uterus were aspirated into the suction catheter x 3. The uterus was then curetted to gritty texture. Excellent hemostasis was noted.

The single-tooth tenaculum and all other instrumentation was removed from the vagina. The bivalved speculum was removed from the vagina. The patient was returned to the recovery room in stable condition.

Dr. ____ was present and scrubbed for the entire case.

Laparoscopic BTL

PREOPERATIVE DIAGNOSIS: Desires permanent sterilization.

POSTOPERATIVE DIAGNOSIS: Desires permanent sterilization.

PROCEDURE: Laparoscopic bilateral tubal ligation

SURGEON:

ASSISTANT:

ANESTHESIA:

INTRAVENOUS FLUIDS:

ESTIMATED BLOOD LOSS:

URINE OUTPUT:

COMPLICATIONS: SPECIMENS: None

DISPOSITION: Stable to recovery room

INDICATIONS: A 29-year-old, G6 P5-0-1-5 female who desires permanent sterilization. FINDINGS: Exam under anesthesia revealed an anteverted uterus approximately 8-week-size, normal shape, no adnexal masses. Laparoscopic survey of the abdomen revealed a grossly normal uterus, tubes, ovaries, bowel, liver, gallbladder and appendix. No intraabdominal adhesions were noted.

DESCRIPTION OF PROCEDURE:

The patient was taken to the OR where anesthesia was administered. The patient was positioned in dorsal lithotomy in the Allen stirrups. The patient was then examined under anesthesia with the above noted findings. The patient was prepped and draped in the normal sterile fashion. A foley was placed with ease. A weighted speculum was placed in the vagina and the cervix was grasped with a single toothed tenaculum. The uterus was sounded to ___ cm. A Hulka uterine manipulator was then inserted in the uterus. Uterine mobility was found to be satisfactory. The speculum was then removed.

After changing gloves attention was turned to the patient's abdomen where a 10 mm skin incision was made in the umbilical fold. The veres step needle was carefully introduced into the peritoneal cavity at a 45 degree angle while tenting up the anterior abdominal wall. Intraperitoneal placement was confirmed by the use of a water-filled syringe. Opening pressure was ___ mmHg. Pneumoperitoneum was obtained. The 10mm port was then placed through the sleeve and the operative laparoscope was introduced into the abdomen with the above noted findings. Attention was turned to the RLQ. 1% lidocaine was injected locally and a 5mm skin incision was made with the scalpel. The 5mm port was placed after introduction the veress needle under direct visualization.

The Kleppenger forceps were then advanced through the second trocar sleeve on the laparoscope and the patient's left fallopian tube was identified and followed out to the fimbriated end. The fallopian tube was fulgurated with a Kleppenger forceps x 3 at approximately 2.5 cm from the cornua. The right tube was fulgurated in similar manner. Excellent hemostasis was noted.

All instruments and ports were then removed from the abdomen. The fascia at the umbilical incision was reapproximated with 0 vicryl. The skin was closed with dermabond. The Hulka was removed with no bleeding noted from the cervix and all other instrumentation was removed from the vagina. The foley catheter was removed. The patient tolerated the procedure well. All counts were correct x 2. The patient was transferred to the recovery room awake, alert and breathing independently.

Dr. ___ was present and scrubbed for the entire case

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.

Total Vaginal Hysterectomy

PREOPERATIVE DIAGNOSES: 1. Dysfunctional uterine bleeding. 2. Acute blood loss anemia.

POSTOPERATIVE DIAGNOSES: 1. Dysfunctional uterine bleeding. 2. Acute blood loss anemia.

PROCEDURES: Total vaginal hysterectomy.

SURGEON:

ASSISTANT:

ANESTHESIA:

INTRAVENOUS FLUIDS:

ESTIMATED BLOOD LOSS:

URINE OUTPUT:

COMPLICATIONS:

SPECIMENS: Uterus and cervix

DISPOSITION: Stable to recovery room

FINDINGS: Exam under anesthesia revealed an approximately eight-week size anteverted uterus with a large amount of blood clot in the vaginal vault. Normal fallopian tubes and ovaries bilaterally. Intraoperative pathology consult showed no evidence of endometrial hyperplasia or malignancy.

DESCRIPTION OF PROCEDURE:

The patient was taken to the operating room where general anesthesia was administered. An exam under anesthesia was performed with the above-noted findings. She was then prepped and draped in the usual sterile fashion in the dorsal lithotomy position with the Allen stirrups.

A weighted speculum was placed in the vagina and a Deaver placed anteriorly. The cervix was grasped with two single-tooth tenaculums. Next, the cervical vaginal epithelium was incised anteriorly with the scalpel. The pubovesical cervical fascia was incised with the Mayo scissors and the bladder mobilized cephalad. The peritoneum was identified and entered sharply with Metzenbaum scissors and the retractor placed into the peritoneal space to retract the bladder anteriorly. A posterior colpotomy incision was made with Mayo scissors and the rectovaginal space was entered. The weighted speculum was then replaced. In a sequential fashion the uterosacral ligaments, the cardinal ligaments and the uterine arteries were clamped, transected, and suture ligated with 0 Vicryl. The anterior and posterior broad ligaments on either side of the uterus were serially clamped, transected, and suture ligated with 0 vicryl until the utero-ovarian ligaments were encountered bilaterally. These were cross-clamped, transected, and doubly suture ligated with a transfixion stitch of 0 Vicryl bilaterally. Excellent hemostasis was noted.

The ovaries and fallopian tubes were inspected with the above-noted findings. Next, a modified culdoplasty stitch, which included the cardinal ligaments bilaterally, was placed using 0 Vicryl as well as the uterosacral ligaments. The vaginal cuff was then closed using 0 Vicryl in a running locking fashion. Excellent hemostasis was noted. The vagina was then packed with Kerlix soaked in Premarin cream.

The patient tolerated the procedure well. All sponge, lap, needle, and instrument counts were correct x2. She was taken to the recovery room in stable condition.

Dr. ____ was present and scrubbed for the entire case.

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.

Diagnostic Laparoscopy for Ectopic Pregnancy

PREOPERATIVE DIAGNOSIS: Suspected ectopic pregnancy.

POSTOPERATIVE DIAGNOSIS: Left ectopic pregnancy.

PROCEDURE: Laparoscopic left salpingectomy

SURGEON:

ASSISTANT:

ANESTHESIA:

INTRAVENOUS FLUIDS:

ESTIMATED BLOOD LOSS:

URINE OUTPUT:

COMPLICATIONS:

SPECIMENS: Left tube with POCs

DISPOSITION: Stable to recovery room

INDICATIONS:

FINDINGS: Exam under anesthesia revealed small, mobile, anteverted uterus. The right tube and ovary were grossly normal. The left fallopian tube was significantly dilated with blood clot and products of conception extruding from the fimbriated end. There was an estimated 200cc blood in the pelvis. There were mild adhesions in the left ovarian fossa involving the fallopian tube and ovary. Liver, gallbladder and appendix appeared grossly normal.

PROCEDURE IN DETAIL:

The patient was taken to the OR where general anesthesia was administered. The patient was prepped and draped in the normal sterile fashion in the dorsal lithotomy position with the Allen stirrups. A Graves speculum was placed in the vagina and the anterior lip of the cervix was grasped with a single-toothed tenaculum. A Hulka tenaculum was inserted without difficulty. The single-tooth tenaculum and Graves speculum were removed from the vagina. Gloves were changed and attention was turned to the abdomen.

After injection of 0.25% Bupivacaine a 5 mm horizontal incision was made at the inferior aspect of the umbilicus with the scalpel. The Veress needle was inserted and adequate pneumoperitoneum was achieved after verification of intraabdominal placement with a saline syringe. Opening pressure was 6 mmHg. The 5 mm trocar was placed. A 30-degree 5 mm laparoscope was inserted through the trocar and the above findings were noted. The patient was then placed in steep Trendelenburg position. Areas in the right and left lateral quadrants were chosen lateral to the inferior epigastric arteries for additional ports. A 5-mm port was placed in the left lower quadrant and an 11mm port was placed in the right lower quadrant under direct laparoscopic visualization. Also, a 5 mm suprapubic port was placed approximately two fingerbreadths above the pubic symphysis. Attention was turned to the left adnexa where a 5 mm LigaSure device was used to transect the tube approximately 1 cm from its cornual attachment. In successive steps, the LigaSure was used to seal and transect the mesosalpinx all the way down toward the fimbriae until the tube was completely detached. The fallopian tube along with clots and products of conception were removed from the abdomen using the Endocatch bag.

The surgical site was re-examined and excellent hemostasis was noted. The left ureter was seen visibly peristalsing. The suprapubic and lateral trocars were removed from the abdomen under direct laparoscopic visualization. The fascial opening at the right lower quadrant trocar site was reapproximated with #0 Vicryl. All skin incisions were reapproximated with Dermabond. The Hulka tenaculum was removed. A Graves speculum was placed in the vagina and hemostasis of the cervix was achieved with silver nitrate. All instruments were removed. The patient tolerated the procedure well. 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.

Abdominal Myomectomy

PREOPERATIVE DIAGNOSES: 1. Pelvic mass. 2. Pelvic pain.

POSTOPERATIVE DIAGNOSIS: Uterine fibroid.

OPERATION: Exploratory laparotomy and myomectomy.

SURGEON:

ASSISTANT:

ANESTHESIA:

INTRAVENOUS FLUIDS:

ESTIMATED BLOOD LOSS:

URINE OUTPUT:

COMPLICATIONS:

SPECIMENS: Myoma

DISPOSITION: Stable to recovery room

FINDINGS: Examination under anesthesia revealed an approximately 14- to 15-week size, mobile globular uterus. Laparotomy findings included an intramural uterine fibroid approximately 10 to 11 cm. Frozen specimen result: a necrotic uterine fibroid with no evidence of malignancy.

PROCEDURE:

The patient was taken to the OR where her general anesthesia was administered. She was prepped and draped in the usual sterile fashion in the lithotomy position with Allen stirrups. A Foley catheter was sterilely placed and gloves were changed. Attention was turned to the patient's abdomen, where a midline vertical incision was made with the scalpel and carried to the underlying layer of fascia. The fascia was incised in the midline and this incision was extended superiorly and inferiorly with Bovie. Next, the peritoneum was identified and grasped with Kelly clamps and entered sharply with Metzenbaum scissors. This incision was extended superiorly and inferiorly with the bovie with good visualization of the bladder. A survey of the patient's abdomen was performed with the above noted findings. Next, the uterus was lifted out of the pelvis and the bowel packed with moist laparotomy sponges. The fundus of the uterus was injected with approximately 10cc of Pitressin in a vertical line with blanching noted. A vertical incision was made through the superficial myometrium to the level of the myoma with a scalpel. The fibroid was grasped with the single tooth tenaculum and the myoma was shelled out using Mayo scissors in the plane of cleavage between the myoma and myometrium. The myometrium was then reapproximated in approximately four to five layers using #0 Vicryl suture. The serosa was closed using #0 Monocryl in a baseball stitch. Excellent hemostasis was noted. The uterus was returned to the abdomen, the laparotomy sponges were removed and the pelvis was irrigated. Again the incision was inspected and excellent hemostasis was noted. The fascia was reapproximated using #1 Maxon. The skin was closed with staples.

The patient tolerated the procedure well. All sponge, lap and needle counts were correct x 2. The patient was taken to the recovery room in stable condition.

Dr. ____ was present and scrubbed for the entire case.

Discharge Summary

PATIENT NAME:

MRN:

DATE OF ADMISSION:

DATE OF DISCHARGE:

ATTENDING: DICTATING:

ADMISSION DIAGNOSES: (list everything including chronic conditions, ie obesity) DISCHARGE DIAGNOSES: (same, list all relevant to admission as well as those diagnosed during the patients stay and then chronic conditions)

H&P: Read the admission H&P and be sure to include the following

CC: HPI: POBHx: PGYNHx: PMHx: PSHx:

MEDS on admission: ALL:

SHx: FHx:

PHYSICAL EXAM ON ADMISSION: (again read this off H&P, if not much info given can say "relevant for" and include what information is given)

LABORATORY RESULTS: IMAGING RESULTS:

ASSESSMENT/PLAN: (again can read off H&P) HOSPITAL COURSE:

This is where you actually have to think. It is best to do the hospital course by system so that you can keep things straight. Basically you need to break it down and then discuss relevant interventions/results/consults/events/etc for each system. If you have things that overlap you can say "see above for details" if you have already gone through a related issue (i.e. postop pain and then pt had desat due to pain meds, you would dictate PAIN section and then under RESP can say had desat on day _ and was managed as stated above)

DISCHARGE: Discharged to home on __ in stable condition

DISCHARGE MEDICATIONS: List all meds as written on dc ppwk

DISCHARGE INSTRUCTIONS: Basically go through instructions on dc ppwk (use as much detail as you want)

FOLLOW-UP: List all scheduled follow-up appointments or can say "patient instructed to call Dr. _____ to make follow-up appointment for one week)

**** VERY IMPORTANT:** when you sign your dictation BE SURE to cc the referring MD (you can find this in the provider tab)

Partial Vulvectomy

MRN:

NAME:

Date of Procedure:

DOB:

Attending:

Dictating:

PREOPERATIVE DIAGNOSIS: Vulvar intraepithelial neoplasm 3.

POSTOPERATIVE DIAGNOSIS: Vulvar intraepithelial neoplasm 3.

PROCEDURE: Exam under anesthesia and partial vulvectomy.

SURGEON:

ASSISTANT:

ANESTHESIA:

ESTIMATED BLOOD LOSS:

FLUIDS:

URINE OUTPUT:

COMPLICATIONS:

CONDITION:.

FINDINGS:

Exam under anesthesia revealed a midline butterfly-shaped raised white lesion involving the entire perineum. The lesion approaches the hymenal ring, but there was no evidence of extension into the vagina. The lesion extends posteriorly over the perineal body but does not extend to the anus. There were no palpable masses or abnormalities on bimanual exam. Rectovaginal exam was confirmatory.

DESCRIPTION OF PROCEDURE:

After informed consent was obtained the patient was taken to the operating room where anesthesia was administered and found to be adequate. The patient was then positioned in the dorsal lithotomy position in Allen stirrups. Exam under anesthesia was then performed yielding the above noted findings. The patient was then prepped and draped in the normal sterile fashion. After injection of .25% marcaine, the scalpel was then used to incise the outlined skin, taking care to leave a 5mm wide margin. The dermis and underlying subcutaneous tissue was excised using Bovie electrocautery. The excision bed was cauterized to obtain excellent hemostasis. The endopelvic fascia was reinforced with 2-0 Polysorb, rebuilding the perineal body. The skin edges were closed with vertical mattress sutures of 2-0 Polysorb. Excellent hemostasis was noted. The patient was awakened in the operating room. She tolerated the procedure well. All instrument, sponge and needle counts were correct x2.

ATTESTATION STATEMENT: Dr. _____ was present, scrubbed, and actively participated throughout the entire procedure.

Cold Knife Cone and Skinning Vulvectomy

PREOPERATIVE DIAGNOSES:

1. Cervical dysplasia, rule out invasive cancer.
2. Vulvar intraepithelial neoplasia - III.

POSTOPERATIVE DIAGNOSES:

1. Cervical dysplasia, rule out invasive cancer.
2. Vulvar intraepithelial neoplasia - III.

PROCEDURES:

1. Cold knife conization.
2. Endocervical curettage.
3. Partial vulvectomy.

SURGEON:

ASSISTANT::

EBL:

FLUIDS:

FINDINGS

Cervix is grossly normal appearing. Vulva has extensive VIN lesions. There is 1 area on the right labia majora that is concerning for possible invasive cancer. There is also scarring especially perianally from prior surgery.

PROCEDURE:

The patient was taken to the operating room where general anesthesia was obtained without difficulty. The patient was prepped and draped in the normal sterile fashion in the dorsal lithotomy position. Straight catheterization of the bladder was performed with 300 cc of urine obtained. A weighted speculum was placed in the vagina. The anterior lip of the cervix was grasped using a single-tooth tenaculum. Lugol's solution was applied to the cervix and minimal non-staining area was seen. Bilateral stay sutures of 0 Vicryl were placed at the cervicovaginal junctions. The cervix was infiltrated with 0.5% lidocaine with epinephrine circumferentially. A cone biopsy was performed sharply. A silk stitch was placed at 12 o'clock on the specimen for orientation. Following removal of the cone biopsy specimen an endocervical curettage was performed. The cone bed was cauterized and made hemostatic. A Surgicel soaked in Monsel's solution was placed into the cone bed and the 0 Vicryl stay sutures were tied over this. Hemostasis was confirmed.

Attention was then turned to the vulva. A bilateral skinning vulvectomy was performed of the most concerning VIN lesions. The bilateral labia majora were removed. The clitoris and clitoral hood were spared.

Following vulvectomy the defects were closed using mattress sutures of 2-0 Vicryl and interrupted sutures of the same. The patient tolerated the procedure well. All instrument counts were correct. The patient was taken to the recovery room in good condition.

Sentinel Node Dissection

MRN:

NAME

Date of Procedure:

DOB:

Attending:

Dictating:

PREOPERATIVE DIAGNOSIS: IB midline vulvar cancer.

POSTOPERATIVE DIAGNOSIS: IB midline vulvar cancer with 2 left and 2 right sentinel lymph nodes that were both hot and blue.

PROCEDURE:

Sentinel lymph node injection, identification, and removal of bilateral inguinal-femoral sentinel lymph nodes.

SURGEON:

FIRST ASSISTANT:

ANESTHESIA:

ESTIMATED BLOOD LOSS:

COMPLICATIONS:

OPERATIVE FINDINGS:

Previously, Tc99 was injected at the leading edge on both sides of the prior midline vulvar scar.

Intraoperatively, Lymphazurin blue, 2.5 mL, was injected at the same sites. The gamma probe, as well as following the Lymphazurin blue channels, were then used to identify the sentinel lymph nodes. There were 2 sentinel lymph nodes on the left. Left sentinel lymph node #1 was blue and hot with the gamma probe measurement of 1471. Left sentinel lymph node #2 was blue and hot with gamma probe measurement of 250. On the right, right sentinel lymph node #1 was blue and hot and the gamma probe measurement was 2287. Right sentinel lymph node #2 was blue and hot, and the gamma probe measurement was 357. There were no other blue or hot areas noted in the dissection beds. The sentinel lymph nodes removed were not grossly suspicious for metastatic disease.

PROCEDURE:

The patient was taken to the operating room, where anesthesia was found to be adequate. She was prepped and draped in the normal sterile fashion in dorsal lithotomy position. Foley catheter was placed in the bladder. 2.5 mL

of Lymphazurin blue was injected into the left leading edge of her incisional scar from her previous vulvar resection. The sentinel node had been previously marked by the nuclear medicine team after her technetium-99 injection the prior day. An approximately 4 cm incision was made overlying the candidate sentinel lymph node parallel to the inguinal ligament. This dissection was then carried down to the underlying layer of the fascia. The fascia was incised and careful dissection was performed until blue channels were noted. The lymph nodes were identified and noted to be hot and blue. These lymph nodes were then carefully dissected away from the surrounding tissue using a combination of cautery and blunt dissection. The sentinel nodes were then measured off the field for a 10 second count, as noted above.

Excellent hemostasis was noted. The area was copiously irrigated. The subcutaneous tissue was then reapproximated with 2-0 Vicryl, and the skin was then closed with a 4-0 Biosyn in a running fashion.

Attention was turned to the right sentinel node dissection; 2.5 mL of Lymphazurin blue was injected in the right leading edge of the previous resection scar. An incision was made over the previously marked lymph node approximately 4 cm parallel to the inguinal ligament. This was carried through to the underlying layer of fascia. The fascia was incised, and careful dissection was performed to find the blue channels. The blue channels were then traced to the blue nodes, which were then carefully dissected away from the underlying tissue with combination of blunt and cautery dissection.

Excellent hemostasis was noted. They were measured off the field, as noted above. Copious irrigation was performed. The fascia was then closed with multiple interrupted sutures. The skin was then closed in a running fashion. The patient tolerated procedure well. Sponge, lap and needle counts were correct x2, and she was transferred to the PACU in stable condition.

ATTESTATION STATEMENT: Dr. _____ was present and participated in the entire procedure.

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.

BETA BOOK CONSULTATION REPORT

DATE OF CONSULTATION:

CONSULTING PHYSICIAN:

EMERGENCY DEPARTMENT OBSTETRICS AND GYNECOLOGY CONSULTATION NOTE

CHIEF COMPLAINT: Vaginal bleeding, positive home pregnancy test.

HISTORY OF PRESENT ILLNESS: Ms. Saunders is a very pleasant 30 year-old, gravida 1 with last menstrual period of December 5, 2011, who presents with 2 days of vaginal bleeding and a positive home pregnancy test that was taken today. The patient states that she usually has regular monthly menstrual periods, and her last was on December 5, 2011. However, the patient states that 2 days ago she began bleeding again, as though she was starting a normal menstrual period and was concerned by this. She called the Health Department and they recommended obtaining a urine pregnancy test at home, which was positive. The patient, therefore, came to the emergency department for further evaluation. The patient denies any abdominal pain. She states that she had some heavier bleeding 2 days ago but that this has now lessened substantially and she is only requiring a panty liner. She denies any dysuria, hematuria. No fevers, chills, nausea or vomiting. This is an undesired pregnancy. The patient was using condoms for birth control only. She is Rh-positive.

PAST OBSTETRICAL HISTORY: Gravida 1.

PAST GYNECOLOGIC HISTORY: The patient has a remote history of chlamydia that was treated approximately 12 years ago. She denies any history of abnormal Pap smears and no sexually transmitted infections since the chlamydia.

PAST MEDICAL HISTORY: Denies.

PAST SURGICAL HISTORY: Denies.

MEDICATIONS: None.

ALLERGIES: No known drug allergies.

SOCIAL HISTORY: The patient smokes 2 cigarettes per day. She drinks alcohol occasionally. She endorses occasional marijuana use. She denies any other illicit drug use. She is currently a graduate student, studying elementary education.

FAMILY HISTORY: Noncontributory.

REVIEW OF SYSTEMS: As per history of present illness, otherwise 12-point review of systems is negative.

PHYSICAL EXAMINATION: Vital signs: Temperature 36.7 degrees Celsius, blood pressure 116/73, pulse 110 (pulse was 74 on repeat examination), respirations 16, oxygen saturation 100% on room air. General: No acute distress, lying comfortably in hospital stretcher bed. Cardiovascular: Regular rate and rhythm. Pulmonary: Lungs clear to auscultation bilaterally. Abdomen: Soft, nontender, nondistended. Normoactive bowel sounds. No rebound or guarding. Extremities: No lower extremity edema or calf pain. Pelvic: Scant blood noted in the vaginal vault. No active bleeding from the cervical os. No cervical motion tenderness. No vaginal or cervical lesions noted.

LABORATORY: The patient's blood type is O-positive. Her complete blood cell count was notable for a hematocrit of 27, white blood cell count of 5.2 and platelets of 292. The patient's basic metabolic panel was unremarkable. The patient's beta HCG value was 202. Urinalysis was obtained that was grossly contaminated with blood from the vagina.

IMAGING: A transvaginal ultrasound was obtained that was negative for intrauterine pregnancy. There was minimal fluid and debris, presumably blood, evident in the endometrial canal. The adnexal areas were normal with no evidence of mass or fluid collection.

IMPRESSION AND PLAN: A 30-year-old gravida 1 with early pregnancy and last menstrual period of December 5, 2011. Likely a spontaneous abortion, given the patient's bleeding over the last 2 days, ultrasound findings and beta HCG value. The patient is Rh-positive and RhoGAM is not indicated. This is an undesired and unplanned pregnancy for the patient. A long discussion was had with the patient regarding our findings and recommendations. It was explained to her that, although this is likely a spontaneous abortion, we cannot completely exclude the possibility of an early normal pregnancy or an ectopic pregnancy. Given this, it is our recommendation that the patient return to the Durham Regional Hospital Emergency Department in 48 hours for a repeat beta HCG measurement. Should this value be decreasing, this bolsters the likelihood that this is a spontaneous abortion. Still, we would like to follow the patient's beta HCG values until they are negative. In the event that the patient's beta HCG value is rising appropriately or has plateaued, the patient may indeed have an ectopic pregnancy and may require surgical intervention. The other possibility is that this is a normal early

pregnancy complicated by first-trimester bleeding which, by definition, would be a threatened abortion. The patient was given strict emergency room precautions on when to return, including heavy bleeding saturating a pad in an hour, extreme nausea or vomiting, severe abdominal pain not responsive to over-the-counter medications, fever and/or chills. The patient verbalized understanding of the plan and was amenable. If the patient's beta HCG value has decreased on her repeat examination, our Duke Gynecology Clinic nurses will give the patient a call on Tuesday, December 27th, to inform her of a subsequent followup appointment to confirm that the patient's beta HCG value has become undetectable.

The patient also has some evidence of iron deficiency anemia as noted by her complete blood cell count. It was, therefore, recommended that the patient be discharged with prescriptions for ferrous sulfate 325 mg to be taken twice daily with food, as well as Colace to help prevent constipation. There were no recent prior hematocrit values to which we could compare the patient's current value. The patient was informed of this anemia, and it was strongly recommended that she follow the prescribed medication regimen.

The plan of care for this patient was discussed with the attending physician on call, Dr. _____ and he agrees with the plan as outlined above.

UroGynecology

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.

Anterior Colporrhaphy and Midurethral Sling

PREOPERATIVE DIAGNOSIS: 1. Cystocele. 2. Genuine stress urinary incontinence.

POSTOPERATIVE DIAGNOSIS: 1. Cystocele. 2. Genuine stress urinary incontinence.

PROCEDURE: Anterior colporrhaphy, Mid urethral sling, Cystoscopy.

SURGEON:

ASSISTANT:

ANESTHESIA:

INTRAVENOUS FLUIDS:

ESTIMATED BLOOD LOSS:

URINE OUTPUT:

COMPLICATIONS:

SPECIMENS: None

DISPOSITION: Stable to recovery room

INDICATIONS:

FINDINGS: Exam under anesthesia revealed an anterior prolapse with good support in the posterior vaginal compartment. The anus and perineum were grossly normal. Intraoperative cystoscopy after placement of the mid urethral sling trocars reveals an in-and-out cystotomy to the right bladder dome. Repeat cystoscopy revealed no evidence of injury.

DESCRIPTION OF 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 supine position with Allen stirrups. A foley catheter was placed. Allis clamps were used to grasp the anterior vaginal epithelium from the bladder neck to the cuff. A total of 10cc of 0.25% Marcaine with epinephrine was injected locally. A midline incision was made along the length of the anterior vaginal epithelium and the epithelium was then dissected sharply away from the underlying connective tissue. Interrupted 2-0 Maxon suture was used for the anterior colporrhaphy. The excess epithelium was trimmed and the incision was closed with running locked 3-0 Vicryl sutures.

The anterior vaginal epithelium over the mid urethra was grasped with the Allis clamps. 10cc of 0.25% Marcaine with epinephrine was locally injected. A 1.5cm mid urethral incision was made in the anterior vaginal epithelium with a #15-blade scalpel. The periurethral connective tissue was dissected on each side of the urethra through the mid urethral incision with the Metzenbaum scissors. A stab incision was made on the mons pubis just above the symphysis pubis one fingerbreadth lateral on each side. A mid urethral sling trocar was passed to the right of the urethra up to the space of Retzius and out the stab incision on the right side. The trocar was advanced completely through the space of Retzius to position the blue tubing within the space of Retzius. This procedure was repeated in an identical fashion on the left. The Foley catheter was removed and a 70-degree cystoscope was placed in the bladder with the above noted

findings. Due to presence of a cystotomy on the right, the blue tubing on the right was removed under direct visualization. The cystoscope was removed and the Foley catheter was replaced. The trocar was passed on the patient's right side. Cystoscopy was repeated with no evidence of lower urinary tract injury noted. Again the cystoscope was removed and the Foley catheter was replaced. The polypropylene sling material was then advanced to the space of Retzius to position the sling at the mid urethra. The plastic sheath was removed. Tension was adjusted to ensure a tension-free placement. The sling material was trimmed at the skin on the mons pubis. The stab incisions were closed with Indermil. The mid urethral incision was closed with running locked 3-0 Vicryl suture.

The patient tolerated the procedure well. 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.

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.

Anterior colporrhaphy, midurethral sling with Bard ALIGN and cystourethroscopy.

PREOPERATIVE DIAGNOSIS:

Stage II anterior vaginal prolapse and stress urinary incontinence.

POSTOPERATIVE DIAGNOSIS:

Stage II anterior vaginal prolapse and stress urinary incontinence.

PROCEDURE:

Anterior colporrhaphy, midurethral sling with Bard ALIGN and cystourethroscopy.

SURGEON:

ASSISTANT:

ANESTHESIA:

General and local with 0.25% bupivacaine with epinephrine.

ESTIMATED BLOOD LOSS:

FLUIDS:

URINE OUTPUT:

SPECIMENS:

DRAINS:

COMPLICATIONS:

CONDITION:

INDICATIONS:

This is a 75-year-old female with stage II anterior wall prolapse and urodynamic stress incontinence during barrier reduction on preoperative urodynamic testing. Preoperatively, we discussed with her the risks, benefits and alternatives of surgery as well as alternative management options and the patient elected to undergo the surgery with midurethral mesh sling. We specifically discussed the risks of mesh placement including pain, mesh erosion, need for further surgery, and then reviewed the FDA notification on this subject. All her questions were answered and written consent was obtained for the above-noted procedure.

FINDINGS:

On cystourethroscopy performed at the end of the procedure, intact bladder and urethra with efflux of clear urine from each of the bilateral ureteral orifices. No bladder masses or lesions. There was excellent anterior vaginal support obtained at the end of the surgery with adequate vaginal caliber and no undue tension.

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 in the bladder and the bladder was drained. The Lone Star vaginal retractor was placed with the hooks placed at the level of the hymeneal ring for retraction and visualization.

The anterior vaginal epithelium was grasped in the midline with the Allis clamps at the level of the vaginal cuff. The bladder neck was palpated and the anterior vaginal wall was grasped 1 cm cephalad to the bladder neck. The anterior vaginal epithelium was infiltrated with 0.25% bupivacaine with epinephrine. A vertical midline incision was made with the 15-blade in the vaginal epithelium 1-2 cm distal to the bladder neck. The vaginal epithelium was retracted laterally and the Metzenbaum scissors were advanced under the vaginal epithelium, dissecting it from the underlying fibromuscular tissue and then serially incising the overlying epithelium up to 1-2 cm distal to the vaginal cuff. The underlying fibromuscular tissue was then dissected sharply to expose the entirety of the cystocele to the level of the pubic rami bilaterally with sharp dissection using the Metzenbaum. The dissection bed was inspected and noted to be hemostatic. The cystocele was serially reduced with vertical mattress stitches of 2-0 Maxon in 1 layer. Once the entirety of the cystocele was reduced, a vaginal exam was performed revealing excellent anterior vaginal support with adequate vaginal caliber and no undue tension. The excess vaginal epithelium was trimmed with the Metzenbaum scissors and reapproximated with 3-0 Vicryl in a running, locked stitch.

The level of the midurethra was palpated and the Allis clamps utilized to grasp the overlying vaginal epithelium. The epithelium was infiltrated with 0.25% bupivacaine with epinephrine and incised in the midline with a 15-blade, performing

a 1-cm vertical midline incision. The vaginal epithelial edges were retracted laterally with the Allis clamps. The underlying fibromuscular tissue was dissected from the epithelial edges with the sharp Metzenbaum scissors. Using the regular Metzenbaums a tunnel was made on both sides of the urethra to the level of the endopelvic fascia. The Bard ALIGN trocar was placed in the right-hand tunnel, advanced through the retropubic space and exiting via stab incision made at the skin at the abdominal wall 1-1/2 fingerbreadths from the midline at the level of the pubic symphysis. In a similar fashion the same was performed on the left-hand side with the trocar through the retropubic space exiting through a stab incision 1-1/2 fingerbreadths from the midline on the left-hand side of the abdomen at the level of the pubic symphysis. The vaginal epithelial edges were inspected to note no evidence of vaginotomy. The Foley catheter was removed and, with the trocars in the retropubic space, a cystourethroscopy was performed with a 17-French 70-degree cystoscope. As noted above, no evidence of cystotomy or bladder injury was visualized, and the bilateral ureteral orifices were seen to be effluxing clear urine. The cystoscope was removed, the Foley catheter was replaced and the bladder was drained. The Bard Align sling was brought through the retropubic space and the mesh was gently adjusted so that it lay flat against the urethra with no undue tension. The excess mesh was trimmed at the level of the abdomen and the abdominal skin was closed with Indermil. The vaginal epithelial edges were reapproximated with 3-0 Vicryl in interrupted stitches.

A transurethral Foley catheter remained in the bladder at the end of the procedure so the patient may undergo a void trial postoperatively. The patient tolerated the procedure well. Sponge, lap, needle and instrument counts are correct x2. The patient was taken out of dorsal lithotomy position and then was awakened from anesthesia. She was transferred to the recovery room awake, alert and breathing independently in stable condition.

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

Bard Align midurethral mesh sling and cystourethroscopy

PREOPERATIVE DIAGNOSIS:

Stress urinary incontinence.

POSTOPERATIVE DIAGNOSIS:

Same.

PROCEDURE:

Bard Align midurethral mesh sling and cystourethroscopy

SURGEON:

ASSISTANT:

ANESTHESIA:

ESTIMATED BLOOD LOSS:

URINE OUTPUT:

FLUIDS:

SPECIMENS:

DRAINS:

COMPLICATIONS:

CONDITION:

INDICATIONS:

This is a 58-year-old female who recently underwent Uphold mesh and cystoscopy on 08/14/2012, who developed postoperative stress urinary incontinence. We discussed the various options for management with the patient preoperatively and she elects to undergo midurethral mesh sling surgery. The risks, benefits, and alternatives of surgery were discussed with the patient and all her questions were answered. We specifically discussed the risks of mesh placement such as erosion, pain, need for further procedures as well as the FDA advisory on mesh products. She verbalized understanding. All her questions were answered written consent was obtained.

FINDINGS:

Cystourethroscopy performed at the end of the procedure revealed no evidence of cystotomy with no bladder masses or lesions with bilateral ureteral orifices appeared patent. Urethra was without injury.

PROCEDURE:

The patient was taken to OR where anesthesia was administered. She was prepped and draped in normal sterile fashion in the dorsal lithotomy position in Allen stirrups. Care was taken upon positioning to avoid any areas of extreme flexion or extension. A transurethral Foley catheter was placed in the bladder and the bladder was drained.

The level of the midurethra was palpated. Allis clamps were used to grasp the overlying vaginal epithelium. The vaginal epithelium was infiltrated with 0.25% bupivacaine with epinephrine and a 1-cm vertical midline incision was made with a 15-blade scalpel. The underlying fibrovascular tissue was dissected away from the vaginal epithelium. Using metzenbaum scissors on the right side a tunnel was made to the level of the endopelvic fascia and a tunnel was made in a similar fashion on the left side. The Bard Align trocar was passed through the right hand tunnel traveling through the retropubic space and exiting through a skin incision 1-1/2 fingerbreadths from the midline at the level of the pubic symphysis. In a similar fashion the Bard Align trocar was placed on the left side.

The catheter was removed and a 70-degree 17-French cystoscope was inserted through the urethra into the bladder with the above-noted findings. The cystoscope was then removed. The Foley was replaced and the bladder was drained.

The vaginal epithelial edges were inspected with no evidence of vaginotomy. The mesh was brought through the incision and noted to lie flatly against the urethra with no undue tension. The mesh was trimmed at the level of the abdomen and the abdominal incisions were closed with Indermil. The vaginal epithelium was reapproximated with 3-0 Vicryl in interrupted stitches.

The patient tolerated procedure well. Sponge, lap and needle counts were correct times 2. All remaining instruments were removed from the vagina. The patient was taken out of dorsolithotomy position and awakened from anesthesia. She was transferred to the Recovery Room awake, alert and breathing independently in stable condition.

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