Operative Report Date of Service: 5/11/2017 5:31 PM

Marie Fidela Paraiso
Urogynecology

OPERATIVE/PROCEDURE REPORT

LOG ID: 2550200
Surgery/Procedure Date: 5/10/2017
Incision/Procedure Start Time: 3:18 PM
Incision Close/Procedure End Time: 6:21 PM

Surgeon(s)/Proceduralist(s) and Assistant(s):
Surgeon(s) and Role:
* Marie Fidela Paraiso - Primary
* Carol Emi (Fel) Bretschneider - Fellow
* Julian (Res) Gingold - Resident - Assisting

Surgical Assistant: Henry (Tech) Kraft

Procedure(s):
1) Laparoscopic sacrohysterocolpopexy
2) Cystoscopy

Anesthesia: General per endotracheal tube

Findings:
Stage 3 Uterovaginal prolapse
Normal uterus and cervix; Normal ovaries and tubes.
Cystourethroscopy: No stitch, mesh or injury to bladder or urethra. Bilateral ureteral jets noted.
Vaginal sweep revealed no foreign body.

Estimated Blood Loss: 75 mls

Specimens: None

Complications: None

Pre-Op/Pre-Procedure Diagnosis: Uterovaginal prolapse, cystocele, pelvic pressure, asymptomatic rectocele

Post-Op/Post-Procedure Diagnosis: Uterovaginal prolapse, cystocele, pelvic pressure, asymptomatic rectocele

Procedure Details: The patient was taken to the operating room where a surgical time-out and safety checklist were performed. The patient was then given prophylactic antibiotics and compression stockings were applied bilaterally. She underwent general anesthesia without any difficulty. She was positioned awake in the dorsal lithotomy position using yellow fin stirrups making sure that her lower extremities were not overly extended or flexed. She was prepped and draped in the normal sterile fashion. A Foley catheter was inserted and the bladder was drained of all urine.

A uterine manipulator was placed in the vagina. Marcaine was used over the umbilicus and a 5mm skin incision was performed. Under direct visualization the trocar was advanced. Once we confirmed entry into peritoneal cavity, pneumoperitoneum was performed without difficulty. Abdominal survey revealed the above noted findings. A 5mm right lower quadrant port was placed followed by a 8 mm and a 5 mm port in the left lower quadrant in the normal fashion. The right ureter was identified and noted to be vermiculating.

The sigmoid colon was moved out of the surgical field using a Carter-Thomspon needle and a 2-0 polysorb stitch through a few epiploica.

We then identified the broad ligament on the left side. A small defect was created through the broad ligament. Care was taken to avoid the uterine artery, ureter and other vessels. A Restorelle Flat L-mesh was fashioned into an Apron and posterior graft. One arm of the mesh was passed through the opening. In a similar fashion the procedure was repeated on the left side. The mesh was then attached anteriorily with 2-0 Maxon. 5 stitches were placed in total.

The posterior mesh was then introduced and was secured with six 0-Maxon stitches. The vagina was then placed in the right pararectal space. The mesh was brought to the sacrum and the repair was noted to support the apex and uterus very well. Two stitches of #0 Prolene were used to attach the mesh to the anterior longitudinal ligament of the sacrum. These were tied down and secured the mesh nicely. Excess mesh was trimmed and removed from the abdomen. The peritoneum was then closed over the mesh using 2-0 biosyn. An additional #2-0 polysorb was used to reinforce the posterior peritoneal closure to make sure all mesh was covered. The closure included the posterior uterine serosa. The anterior bladder flap incision was closed with a purse string closure as well. The area was irrigated and noted to be hemostatic. Pressure was dropped to 10mm Hg and excellent hemostasis was till noted.

A cystoscopy was performed. The bladder was noted to have normal bladder mucosa with no defects, sutures, mesh or injuries. Efflux was noted from the bilateral ureteral orifices. The Foley catheter was replaced once the cystoscopy was done. A vaginal exam confirmed good hemostasis and excellent support even with concomitant pneumoperiteum.

The entire surgical site was irrigated and suctioned dry. Confirmation of good closure was done. CO2 gas was then allowed to escape. All areas were noted to be hemostatic and all ports and trocars were removed under direct visualization. The skin was closed with 4-0 biosyn and dermabond.

Sponge, lap, and needle count were correct x2. Anesthesia was reversed. The patient was extubated and transferred to the PACU in stable condition.

Dr. Paraiso was present and scrubbed for the entire procedure and was the primary surgeon during this surgery.

SIGNATURE: Carol Emi Bretschneider, MD
DATE: May 12, 2017
TIME: 7:42 AM

I reviewed, edited, and concur with this operative report.
Marie Fidela R Paraiso, MD

Electronically signed by Marie Fidela Paraiso at 5/15/2017 9:27 AM