Laparoscopy Unit of BKLWRMC

Chief Laparoscopic Surgeon	Anaesthesia Team
Dr. Rakesh Hasabe	Dr. Shailendra Patil
Assistant Laparoscopic Surgeons	Dr. Kashinath Jadhav
Dr. Sagar Karande	Dr. Apurva Rajapurkar-Patil
Dr. Parth Ponkshe	Dr. Rajesh Pawar
Dr. Pooja Gandhi	Dr. Sumit Patil
OT Nursing Staff	**OT Technician**
Jadhav Sister	Kashinath Chavan
Aniket Pawar	Vivek Gudekar
Pranav Salvi	Mandar Nirmal
Suraj Goriwale	

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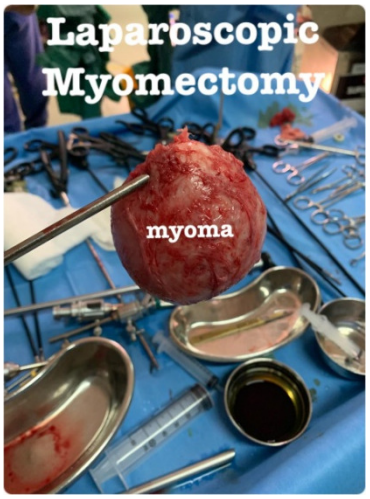
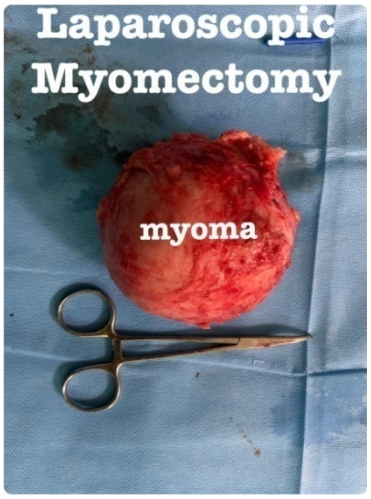
CASE REPORT

Laparoscopic Myomectomy…

A **17-year-old unmarried female** was referred to BKL Walawalkar Hospital by a private practitioner due to **severe dysmenorrhea and excessive bleeding** during menses. On per abdominal examination, the uterus was found to be enlarged to an approximately **16-week size**. A **hard globular mass**, which could not be separated from the uterus, was appreciated on palpation. The patient was advised a USG scan, which revealed a **15 x 14 cm hybrid fibroid with all three components- intramural, submucosal, and subserosal**. As the patient was unmarried, **preserving her fertility** was of utmost importance. Hence, a **Laparoscopic Myomectomy** was planned.

The patient was prepared preoperatively and shifted to the OT. During the laparoscopic procedure, the USG findings were confirmed. **5 IU Vasopressin was diluted in 200 ml NS** and injected into the fibroid using an **irrigation needle**. The **myomectomy** was completed using **Ligasure and Bipolar**. A **handheld suction instrument** is also an ideal instrument for difficult dissections of this type. The most important strategy here is to carefully **identify the right planes to avoid excessive blood loss**. In the case of this patient, the intraoperative blood loss was **not more than 100 ml** and her post-operative Hb was **9 gm%**. Her catheter was removed 12 hours post-surgery and per oral intake was started 8 hours post-surgery. The patient is on track to be discharged home 24 hours post-surgery.





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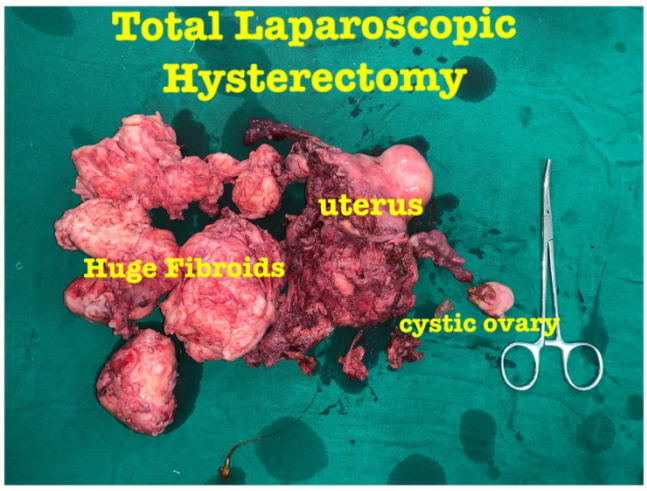
CASE REPORT

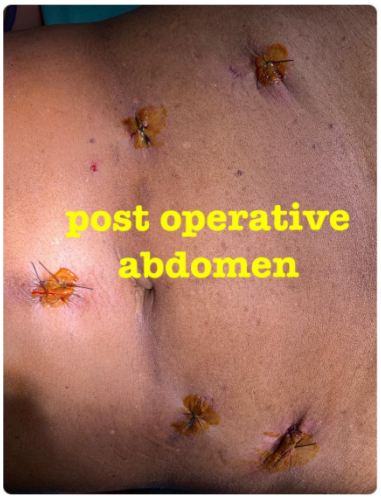
TLH with Laparoscopic Myomectomy…

A **43-year-old female** presented in the OPD at BKLW Rural Hospital with symptoms of **severe pain and pressure in the abdomen**. She also complained of **dysmenorrhea**. She was further investigated to reveal a **huge fibroid of about 20 x 25 cm** along with other **multiple small fibroids**. She was advised Laparoscopic **Myomectomy** as well as **Total Laparoscopic Hysterectomy** but she preferred TLH over myomectomy and hence was posted for the same.

On **diagnostic laparoscopy**, a huge **fibroid of about 20 x 25 cm** was located on the right side of the uterus **blocking the right-sided uterine artery** and other structures making it **extremely challenging** to operate. On the left side, another fibroid measuring **4 x 5 cm** was found. In view of the operative difficulty during the procedure and no potential for intra-abdominal manipulation, a decision to perform an **intraoperative myomectomy** was taken in order to separate out the **20x 25 cm sized myoma**.

The rest of the TLH procedure proceeded in a routine manner. The uterus, the huge myoma, and other operative specimens were retrieved vaginally by **vaginal coring** technique. Hemostasis was confirmed and the procedure completed successfully. Post-operatively, the patient is doing absolutely fine.





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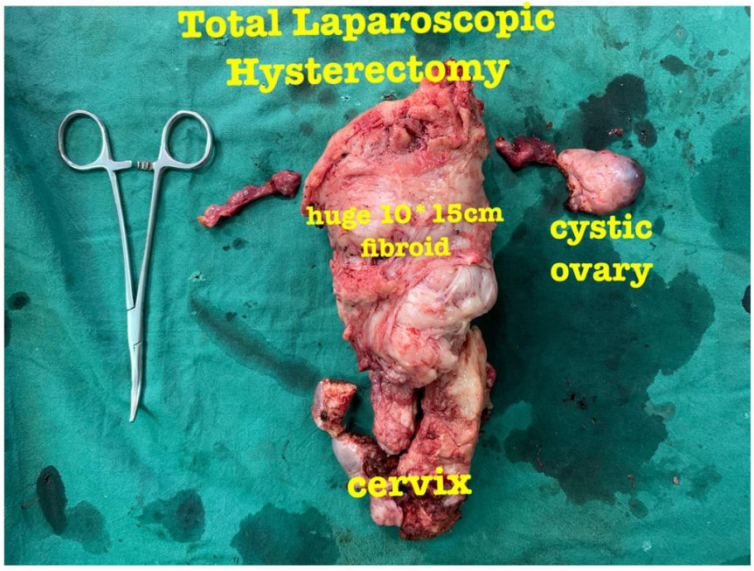
CASE REPORT

TLH with Bilateral Salpingectomy

A **44-year-old female** presented in the OPD at BKL Walawalkar Rural Medical College with **severe dysmenorrhea and abnormal uterine bleeding**. She was being managed conservatively with oral medication for about 6 months with **no notable relief** of symptoms. She was further investigated with USG to reveal a **huge fundal fibroid of around 10 x 15 cm**. In view of her age and long-standing severe symptoms, she was advised **Total Laparoscopic Hysterectomy with B/L Salpingectomy**. She was prepared and posted for surgical intervention.

On diagnostic laparoscopy, the finding of a **huge fundal fibroid of about 10 x 15 cm** was confirmed. The size and extent of the fibroid had the potential to make the procedure difficult as vaginal manipulation does not offer a feasible solution in this case. In such cases, manipulation with a **Myoma Screw** is the preferred mode of manipulation.

This procedure was completed with **Harmonic**. The procedure time was around **45 minutes with minimal blood loss**. The specimen was retrieved vaginally by **vaginal coring** technique. Hemostasis was confirmed and the patient was discharged within 24 hours of the procedure.



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CASE REPORT

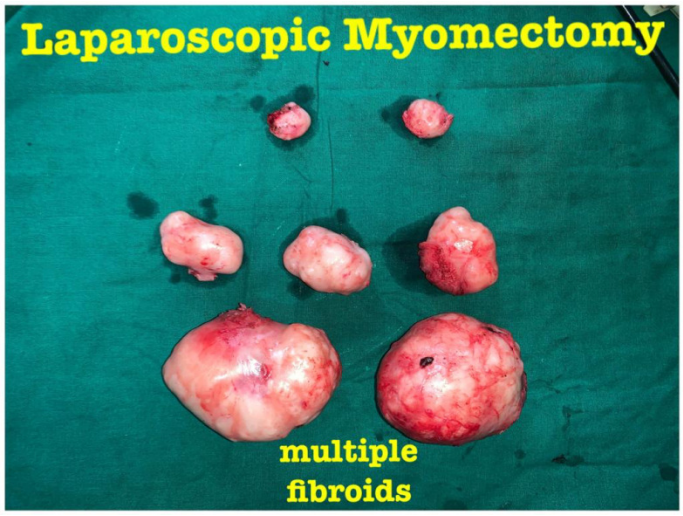
Multiple Fibroid Myomectomy…

A **38-year-old female** presented at BKLW Rural Medical College with complaints of **dysmenorrhea, pain in lower abdomen, and inability to conceive**. She was further investigated with USG and was diagnosed with **multiple uterine fibroids, 6-7 in number, with the largest measuring about 6 x 7 cm in size**.

Due to her desire to carry successful pregnancies in the future, she opted for **conservative management**. She was offered medicinal treatment with **UPA or GnRH**. However, she chose **Laparoscopic Myomectomy** over all other conservative modalities.

On diagnostic laparoscopy, the USG finding of multiple fibroids was confirmed. **Vasopressin 5 IU diluted in 400 ml NS** was injected into each of the fibroids and myomectomy was successfully performed. **Seven fibroids of variable sizes** were removed smoothly **without excessive bleeding**. All the fibroids were removed through a **3 cm suprapubic incision** over the abdomen.

Post-operative recovery was so **quick** that the catheter was removed only 12 hours post-surgery. She was allowed a normal diet within 24 hours and will be discharged within 36 hours. I am hereby sharing the images of the laparoscopically retrieved specimens.



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CASE REPORT

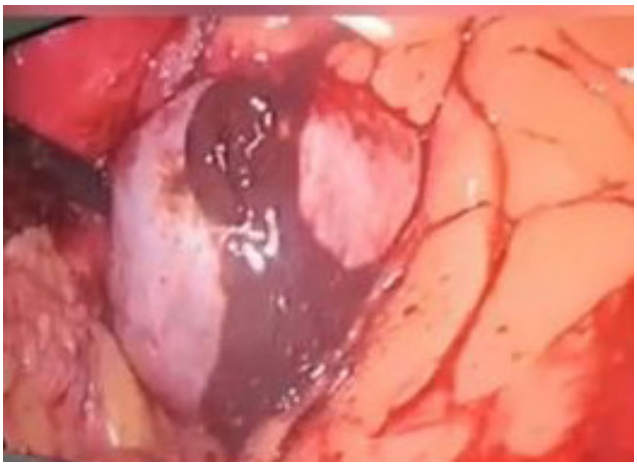
Chocolate Cyst Excision & Adhesiolysis

A **38-year-old female** presented at BKLW Rural Medical College with **primary infertility, severe dysmenorrhea, and severe intermittent pain in the lower abdomen**. She presented with complaints of **typical congestive type of dysmenorrhea**. She was further investigated with USG, which revealed a **chocolate cyst of about 4 x 3 cm in the right ovary**. She was further investigated with an MRI Abdo + Pelvis, on which the findings of the chocolate cyst were confirmed. It further showed presence of **intra-abdominal adhesions**. She was subsequently posted for **diagnostic laparoscopy**, on which the MRI findings were confirmed. The **omentum was found entirely covering the uterus** and **attached at several places** to the anterior abdominal wall. There was **no possible entry into the pelvis and the uterus was not readily visible**.

Extensive adhesiolysis was done using harmonic at various places. It was extremely difficult to perform, requiring extensive knowledge of human anatomy. The **uterus and ovary were exposed** after adhesiolysis. A **chocolate cyst of around 4 x 3 cm was confirmed in the right ovary**. The fallopian tube was adherent to the ovary, forming a **tubo-ovarian complex**. A small nick was given on the ovary and all the **chocolate colored material was suctioned out** avoiding any spillage. **Cyst wall excision** was completed using the **traction and counter-traction** method. Hemostasis was confirmed using bipolar, and irrigation and suction was done.

Cases like this one require **extensive knowledge of anatomy and extreme surgical expertise**. Avoiding extensive dissections and consistently focusing on the main purpose of surgery is pertinent to preventing unnecessary dissections and unfortunate complications.

This patient was discharged on the day following surgery and was prescribed **Inj Provera Depo**. She has been advised against trying for conception for the **next 3 months**, after which she can try conceiving again.



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CASE REPORT

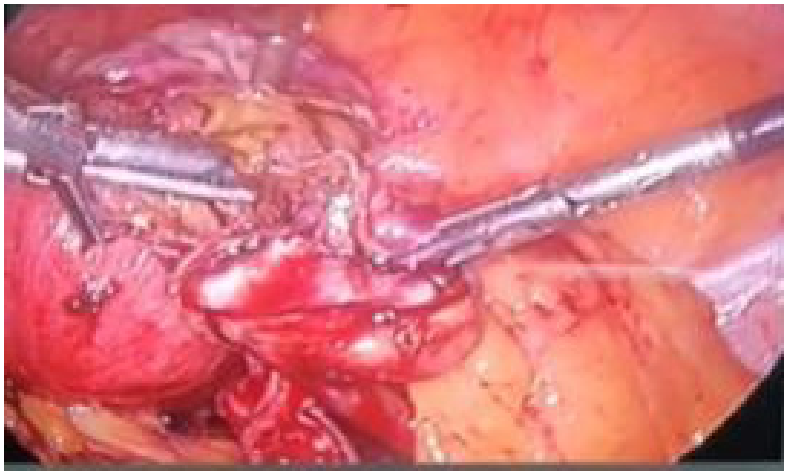
Endometriosis…

Endometriosis is considered akin to a curse for women due to its widespread effect not only on **reproductive ability** but also the associated **severe abdominal pain**, which may or may not be related to the menstrual cycle.

The treatment of endometriosis is equally difficult. There are two ways of treating this condition- first, a **conservative approach**, which means managing it with **GnRH analogues, continuous OCPs, and Progesterone Depots, etc.** However, if the patient is **not managed effectively with medication, if the endometrioma is greater than 4cm in size, or if the patient is suffering from longstanding infertility**, one should opt for the second option of obtaining **surgical clearance** for managing this condition.

Because of the **distorted anatomy**, surgery requires **extreme expertise**. If one is not careful, one might end up damaging the **bowel, bladder, or ureter** leading to unwanted complications.

The attached image is from a procedure for **laparoscopically excised endometrial cyst wall** in my patient diagnosed with **primary infertility**. The patient was discharged home **within 48 hours** of the procedure.



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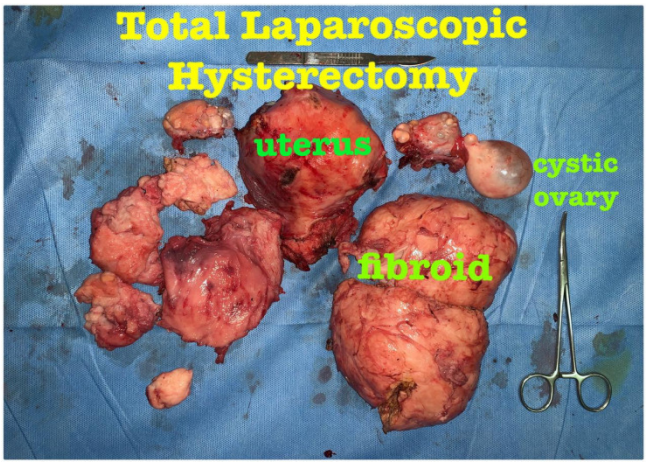
CASE REPORT

TLH with Myomectomy using Vaginal Coring

A **46-year-old female** presented in the OPD at BKLW RMC with **Abnormal Uterine Bleeding** since the last 2 years. For several weeks, she was receiving oral medication and treatment from a private practitioner with **no resolution**. She was advised **hysterectomy** by the outside gynecologist. At BKLW RMC, her USG was found to have a **huge fibroid about 12 x 15 cm** in size. Her **MRI Abdomen-Pelvis** confirmed the USG findings and revealed that the **fibroid was indenting into the endometrium**. In view of her age, a **Total Laparoscopic Hysterectomy** was planned and executed safely.

Intra-operatively, the huge fibroid made **uterine manipulation extremely difficult**. In cases like this, vaginal manipulation does not play any critical role. Instead, one has to rely entirely on **intra-abdominal uterine manipulation using myoma screw**. Retrieving such a huge myoma vaginally was a difficult task, for which **vaginal coring** was employed. In itself, vaginal coring is an art. The entire specimen was successfully retrieved vaginally.

The patient was **morbidly obese with extreme central obesity**. If operated using open technique, such patients have a high tendency to develop **complications** like wound gape. Also, because of prolonged immobilization in bed during the post-operative period, they tend to have more chances of **thrombo-embolic** events. **Laparoscopy** is a boon for such patients and does wonders in the post-operative recovery period.



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CASE REPORT

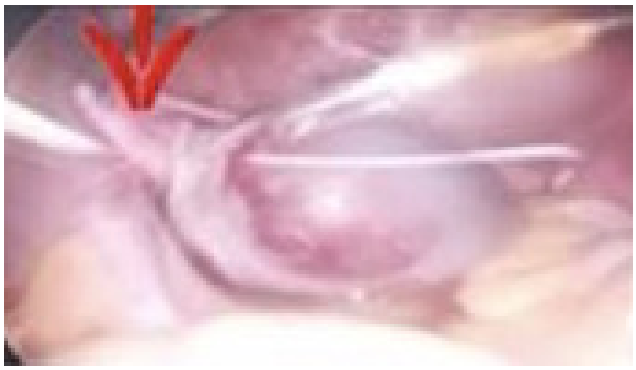
Laparoscopic Ovarian Detorsion w/ Ovarian Ligament Plication & Oophoropexy

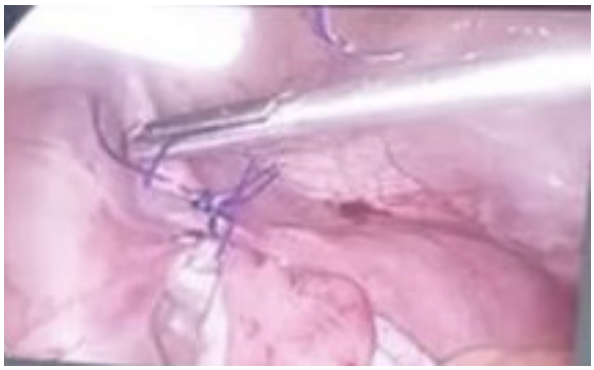
A **21-year-old** unmarried female presented in the OPD at BKLW Hospital with complaints of **severe pain in abdomen**. On USG, she was diagnosed with **Ovarian Torsion with a huge Haemorrhagic Cyst** of about **6 x 7 cm**.

Considering her age and unmarried status, it was **crucial to preserve her ovary**.

She was admitted and posted for **Laparoscopic Ovarian Detorsion with Plication of Ovarian Ligament with Oophoropexy**.

The entire procedure was completed laparoscopically **within an hour**. The patient was discharged home **24 hours** after the surgery.





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