

Radiology Report
03/21/2007

Transvaginal Sonogram

Chief Complaint: Patient complains of severe, low abdominal and left pelvic pain

Findings:

The uterus is anteverted and measures 8.8 x 4 x 3.4 cm. The uterus is homogenous in echogenicity and normal in contour. The uterus is displaced anteriorly and to the left.

The endometrium is not well seen and measures 7 mm.

The right ovary is not seen.

The left ovary is likewise not visualized. In the left adnexa, extending to the cul-de-sac, a large complex soft tissue mass is present and measures 15.1 x 14.2 x 7.4 cm. The mass is complex with both solid and cystic components. The solid component with papillary nodular changes is diffusely heterogenous.

There is large amount of free fluid present in cul-de-sac. The fluid contains low level echoes perhaps blood. Small amount of free fluid is also present in the upper abdomen.

Impression:

Large complex mass in the left adnexa most likely originated from the left ovary. The findings are highly suspicious for left ovarian neoplasm. The complex free fluid in the pelvis and abdomen may be secondary to the metastatic disease or perhaps partial rupture of the mass as patient complains of severe pain.

Operative Report
03/22/2007

Preoperative Diagnosis: Pelvic mass with ascites
Postoperative Diagnosis: Ovarian carcinoma

Operative Procedure: Exploratory laparotomy, total abdominal hysterectomy, bilateral salpingo-oophorectomy, total omentectomy, tumor debulking with a right diaphragmatic stripping

Anesthesia: General endotracheal intubation
Incision: Midline vertical incision
Closure: Loop 1 PDS suture for fascia closure and staples for skin closure

Estimated Blood Loss: 400 mL
Blood Transfusion: None
IV Fluid: 4400 mL of crystalloids
Urine Output: 75 mL
Sponge Counts: Correct x 2

Specimen:

1. Left tube and ovary, which were sent for frozen section and confirmed papillary serous adenocarcinoma
2. Uterus with cervix, right tube and ovary
3. Omentum
4. Right hemidiaphragm peritoneum
5. Pelvic nodules

Postop Status: The patient was in stable, awake and extubated condition to the recovery room.

Intraoperative Findings: The patient was found to have approximately 500 mL of blood-tinged ascites. There were bilateral adnexal masses with the right side measuring approximately 14 x 10 cm and left side measuring 6 x 7 cm. Both adnexa with gross tumors and there were also gross tumors on the left posterior cul-de-sac. The uterus was small in size, however, was with a small serosal implant on the posterior aspect of the uterus. The cervix was negative for gross disease. There were numerous small tumor nodules on the small and large bowel serosa, and also on the mesentery. There was omental cake measuring approximately 10 x 5 cm and there gross tumor on right hemidiaphragm, which was completely stripped and removed and sent to pathology. The tumor was optimally debulked with no residual disease larger than 1 cm.

Procedure: The indications, benefits, potential risks, and complications of the procedure were explained to the patient. All questions were answered, written consent obtained and after appropriately identifying the patient, the patient was taken to the operating room and after achievement of adequate general anesthesia, the patient was frog-legged and the examination under anesthesia was then performed.

The vagina and peritoneum were then prepped with Betadine solution and Foley catheter inserted into the patient's bladder for drainage of urine. The patient was then placed back to the supine position and the abdomen was then prepped and draped in the usual sterile fashion.

A midline vertical skin incision was then made from approximately 15 cm above the umbilicus and carried all the way down to the superior margin of the pubic symphysis in the midline. Subcutaneous tissue was then sharply taken down with an electrocautery Bovie and the fascia then nicked in the midline with a cutting electrocautery Bovie and fascial incision was then extended superiorly and inferiorly with a cutting electrocautery Bovie. The rectus muscle was then separated in the midline, and then the peritoneum was then identified and entered sharply with Metzenbaum scissors. The peritoneal incision was then extended superiorly and inferiorly with electrocautery Bovie. A Bookwalter retractor was then placed to retract the abdominal incision and the abdomen and pelvis were then carefully evaluated with the findings noted as above. The blood-tinged ascites was first drained with the suction and there were approximately 500 mL of blood-tinged ascites.

We then proceeded to open the bilateral pelvic sidewall peritoneum with electrocautery Bovie. The pelvic sidewall peritoneal incision was then made along the lateral border of the infundibulopelvic ligament. Bilateral round ligaments were then doubly clamped with the mixer clamps, transected, and suture ligated with 0 Vicryl suture ties. The peritoneal incision was then carried anteriorly along the vesicovaginal fold and the bladder flap was then created by careful sharp and blunt dissection of the bladder off the anterior cervix and anterior vagina. Bilateral perirectal and perivesical spaces were then developed, and the bilateral obturator spaces.

We first paid attention to the left adnexal mass. The left infundibulopelvic ligament was then identified, and doubly clamped with the Heany clamps, transected and ligated by first placing a 0 Vicryl free tie, followed by a 0 Vicryl suture tie. The left adnexal pedicle was then briefly skeletonized along the inferior border of the ovarian suspensory ligaments and the proximal left fallopian tube and ovarian suspensory ligaments were doubly clamped with the Heany clamps and transected. The specimen of the left tube and the ovary were removed and sent to pathology for frozen section, which confirmed to be papillary serous adenocarcinoma.

We then proceeded to ligate the right infundibulopelvic ligament in the similar fashion by using double Heany clamps to doubly clamp the right infundibulopelvic ligament, transect it and ligate it by placing a 0 Vicryl free tie on the pedicle and followed by 0 Vicryl suture ties.

The bilateral uterine arteries were briefly skeletonized and then doubly clamped with Heany clamps. The uterine arteries were then transected and suture ligated with 0 Vicryl suture ties.

Bilateral paracervical tissues were then serially clamped with Heany clamps, transected and suture ligated with 0 Vicryl suture ties. This was repeated until we reached the level of the external cervical os and then the vagina was cross-clamped with double Heany clamps and then the vagina was transected. The specimen of the uterus together with the cervix, right tube, and ovary were then removed and sent to pathology for permanent section.

The vaginal cuff was then closed with 0 Vicryl sutures in the figure-of-eight fashion and good hemostasis was then obtained. There were small tumor nodules in the posterior cul-de-sac, which was trimmed off the posterior cul-de-sac with the Metzenbaum scissors and all the tumor nodules were safely debulked in the posterior cul-de-sac.

We then paid attention to the omental cake. The omentum was then stretched, mobilized and detached from the transverse colon with electrocautery Bovie. Small perforating vessels were ligated with the LDS staplers, and after we mobilized the infracolic omentum from the transverse colon, we continued to mobilize the supracolic omentum and detach them from the greater curvature of the stomach. Once again, the perforating vessels were ligated with LDS staplers and the omentum between this hepatic flexure and splenic flexure were completely removed including the 10 cm x 5 cm omental cake. This specimen was sent to pathology for permanent specimen.

All the vesicle pedicles were reassured to be with good hemostasis. We then run the small and large bowels from the ligament of Treitz, first all the way down to the ileocecal valve. Small tumor nodules on the small bowel serosa and also on the mesentery were trimmed off with Metzenbaum scissors and then rerun the large bowel from the ileocecal valve all the way to the sigmoid colon and down to the rectum. There were no gross residual tumors larger than 1 cm and these were all millimeter diseases.

We then examined the bilateral kidneys and renal glands and they were all normal without any gross tumor, and the spleen was also normal on palpitation and inspection. There was no gross disease.

The left hemidiaphragm was clean without any tumor nodules, but however, the right hemidiaphragm along with the right retro hepatic recess were filled with tumor nodules. The peritoneum on the right hemidiaphragm was then stripped off with careful blunt and sharp dissection of the peritoneum of the muscle of the diaphragm. This was performed until we reached the posterior aspect of the retro hepatic recess. The falciform ligament was sharply taken down with electrocautery Bovie so we could mobilize the liver and the entire peritoneum covering the right hemidiaphragm was stripped off together with the tumor nodules and there were no residual tumors greater than 1 cm.

At this point, we copiously irrigated the abdomen and pelvis with clean water and all the vesicle pedicles were reassured to be with good hemostasis. We also examined the bilateral pelvic and para-aortic lymph nodes and found no enlarged lymphadenopathy.

We then placed a #10 flat Jackson-Pratt drain to the right lower quadrant of the abdominal wall draining the right pericolic gutter and along the hepatic area. The fascia was then closed with a loop 1 PDS suture in a continuous running fashion from both angles amid to the midline. Subcutaneous tissue was then briefly irrigated and the skin incision was then re-approximated with stainless steel staples. The patient tolerated the procedure well and later went to recovery room in stable, awake, and extubated condition. All the needle, instrument, and sponge counts were correct x 2.

Pathology Report
03/22/2007

Clinical History: Ovarian carcinoma, exploratory laparotomy

Gross Description:

The specimen is labeled left tube and ovary and consists of a multicystic ovary measuring 11 x 8 x 7 cm with attached fallopian tube measuring 7.5 cm in length and 1 cm in diameter. Sectioning of the ovary reveals multiple cystic spaces containing pink clear fluid and multiple red brown papillary proliferations located on the external and internal surfaces of the cyst wall. The fallopian tube shows moderate congestion. RS 15 cassettes

Frozen Section Diagnosis:
Malignant

Final Diagnosis:

Ovary and fallopian tube, left salpingo-oophorectomy: Ovary extensively infiltrated by moderately differentiated serous cystadenocarcinoma (11 x 8 x 7 cm). Fallopian tube focally infiltrated by ovarian adenocarcinoma.

Non-Gyn Report
03/22/2007

Clinical History: Ovarian ca

Specimen:
Ascitic fluid

Gross Description:
50 ml cloudy yellow fluid

Final Cytologic Diagnosis:

Interpretation:
Negative for malignant cells.
Reactive mesothelial cells
Inflammation

Cell block: A few clusters of atypical cells, reactive mesothelial cells

Specimen Adequacy: Satisfactory for evaluation

Pathology Report
03/22/2007

Clinical History: Ovarian carcinoma, exploratory laparotomy, TAH and BSO

Gross Description:

The specimen is received in four parts:

- A. Labeled peritoneum of right hemidiaphragm and consists of multiple portions of yellow and tan brown membranous tissue measuring 7.7 x 6.2 x 2.8 cm in aggregate. Multiple tan nodules ranging in size from 0.2 to 2.7 cm are noted on the surface of the membranous tissue. RS 6 cassettes
- B. Labeled right adnexa, uterus and cervix and consists of a uterus with cervix and a multicystic mass. The uterus measures 9.3 x 5.1 x 4.2 cm and weights 96 grams. The external surface of the uterus is tan brown and smooth. The exocervix is tan and smooth. The external os measures 0.4 cm in greatest dimension and is patent. The endocervical canal measures 3.3 cm in length and is lined by trabeculated pink mucosa. A cervical polyp measuring 1.5 x 0.5 x 0.4 cm in attached to the endocervical canal mucosa. The endometrial cavity measures 4.1 x 2.8 cm and is lined by grossly unremarkable endometrium that measures up to 0.1 cm thickness. The myometrium measures up to 1.1 cm in thickness and is red and rubbery. An intramural mass measuring 1.6 cm in greatest dimension is noted with the right wall of the uterine cavity. The multicystic mass received separately measures 9.8 x 8.2 x 6.7 cm and shows multiple tan-brown papillary projections on the surface of the cyst wall. The attached fallopian tube measures 6.3 cm in length and up to 1.2 cm in diameter. It shows moderate congestion. RS 18 cassettes.
- C. Labeled pelvic nodules and consists of multiple tan and tan-brown masses measuring 2.7 x 2.4 x 0.8 cm in aggregate. ES 2 cassettes
- D. Labeled omentum and consists of a portion of omentum measuring 42 x 14.4 x 2.8 cm. A nodular mass measuring 4.1 cm in greatest dimension is attached to the omentum. Also attached to the omentum are smaller tan masses ranging in size from 0.4 to 1.6 cm. Sectioning of the masses reveal tan and yellow cut surface. RS 6 cassettes

Final Diagnosis:

- A. Portions of peritoneum and attached fragment of diaphragm showing multiple foci of metastatic moderately differentiated serous adenocarcinoma ranging in size from 0.2 to 2.7 cm.
- B. Uterus, cervix and right adnexa, hysterectomy and right salpingo-oophorectomy: Cervix with ectocervical/endocervical polyp. Adenomyosis. Multiple foci of metastatic serous adenocarcinoma within the parametrium. Ovary extensively infiltrated by moderately differentiated papillary serous cystadenocarcinoma of the ovary. Fallopian tube with serosal implants of serous adenocarcinoma.
- C. Multiple portions of mesothelium lined dense fibrosis tissue diffusely infiltrated by metastatic moderately differentiated serous adenocarcinoma. Foci of necrosis, interstitial hemorrhage as well as numerous psammoma bodies are present.
- D. Portion of omentum showing multiple foci of metastatic moderately differentiated serous adenocarcinoma ranging in size from 0.4 to 4.1 cm.

Patient MR# 666601
Patient Name: Olivia Olmos

GYN Advanced Case #1
Page 7 of 8

Radiology Report
03/24/2007

XR Portable Chest

Clinical History: Chest AP portable

Lungs show evidence of pulmonary venous congestion, small bilateral effusion and right basilar linear atelectasis. Underlying pneumonic infiltration at right lung base cannot be completely ruled out. Clinical correlation is advised.

Impression:

Pulmonary venous congestion and small bilateral pleural effusions. Right basilar atelectasis.

Radiology Report
03/24/2007

CT Chest w/Infusion

Clinical History: Evaluation for pulmonary embolism

Multiple spiral CT images of chest are obtained with intravenous administration of the contrast materials, using spiral CT protocol for pulmonary embolism.

Pulmonary artery and its branches up to segmental levels are well opacified and show no focal or linear filling defects to suggest pulmonary embolism. Aorta is unremarkable.

There are small enlarged lymph nodes seen in the pre and paratracheal, precarinal, right hilum and aortopulmonary window regions.

There are extensive alveolar densities in the upper lobes and right middle lobe and patchy densities in the left lower lobe and lingula suggesting infiltrates or less likely edema. There is infiltration atelectasis of right lower lobe and right middle lobe. Slight atelectasis of left lower lobe is also seen. There is small right effusion. There is also small right pneumothorax, 5 percent.

There are streaky changes in the omentum inferior anteriorly about the hepatic flexure. Correlation with the CT scan of abdomen is suggested.

Impression:

No CT evidence of pulmonary embolism.

Mediastinal lymphadenopathy as described.

Extensive infiltrates or edema in the upper lobes and patchy into lingual and left lower lobe. Infiltration and atelectasis of right lower lobe and partially right middle lobe.

Small right pleural effusion.

Small right pneumothorax, 5 percent. Follow-up is suggested.

Streaky changes in the omentum inferior anteriorly about the hepatic flexure. Correlation with the CT scan of abdomen is suggested.

The findings are discussed with medical intern.