Op Note by Kang, Hey Joo, MD at 11/9/2024 8:41 AM

Author: Kang, Hey Joo, MD | Service: Ob/Gyn - Ambulatory Care | Author Type: Attending
Filed: 11/9/2024 9:29 AM | Date of Service: 11/9/2024 8:41 AM | Status: Addendum
Editor: Kang, Hey Joo, MD (Attending)
Related Notes: Original Note by Kang, Hey Joo, MD (Attending) filed at 11/9/2024 5:57 AM

Complications: None, patient tolerated the procedure well.

Attestation: I was present for the entire procedure.

Operative Note

Surgery Date: 11/9/2024
Patient Name: Julee Song
MRN: 1401709761
Date of Birth: 5/18/1982

Pre-operative Diagnosis:
1. Ovarian follicles
2. Patient undergoing assisted reproductive surgery

Post-operative Diagnosis: Same

Procedure: Ultrasound-guided aspiration of ovarian cysts

Surgeon: Hey Joo Kang, MD
Assistant: None

Anesthesia: MAC
EBL: Minimal
Fluids Replaced: Crystalloid
Complications: None

Findings: 6 oocytes recovered

Indications:
Julee Song is a 42 year old female undergoing ultrasound-guided aspiration of ovarian follicles for assisted reproductive surgery

Procedure:
Consents were re-affirmed and re-signed with the patient. The patient was then brought to the OR. After suitable MAC anesthesia was administered, the patient was prepped and draped in the usual sterile fashion. A transvaginal ultrasound was performed with a sterile draped probed with a needle guide attached. Using a 16G Cook aspiration needle and a negative pressure of 80 mmHg, all of the follicles were serially aspirated and the follicular fluid was sent to the IVF laboratory.

Once all of the follicles were aspirated, a sterile vaginal speculum exam was performed and hemostasis was obtained. The patient was then placed in a dorsal supine position and transported to the recovery room using a surgi-lift having tolerated the procedure well.

I was present and scrubbed for the entirety of the procedure.

Hey Joo Kang, MD

Date Collected: **03/08/2025** Date Received: **03/08/2025** Date Reported: **03/14/2025** Fasting: **No**

Ordered Items: **FSH and LH; Free T-3; Cortisol; ACTH, Plasma; Prolactin; IGF-1; Thyroid Stim Immunoglobulin; T4, Free; T3; TSH; Thyroglobulin Antibody; Thyroid Peroxidase (TPO) Ab; Venipuncture**

Date Collected: **03/08/2025**

FSH and LH

Test	Current Result and Flag	Previous Result and Date	Units	Reference Interval
LH [01]	9.6	5.6 12/23/2020 Adult Female Follicular phase Ovulation phase Luteal phase Postmenopausal	mIU/mL Range 2.4 - 12.6 14.0 - 95.6 1.0 - 11.4 7.7 - 58.5	
FSH [01]	6.7	5.1 12/23/2020 Adult Female Follicular phase Ovulation phase Luteal phase Postmenopausal	mIU/mL Range 3.5 - 12.5 4.7 - 21.5 1.7 - 7.7 25.8 - 134.8	

Free T-3

Test	Current Result and Flag	Previous Result and Date	Units	Reference Interval
Free T-3 [02]	2.8 Reference Range: >=20y: 2.0 - 4.4		pg/mL	

Cortisol

Test	Current Result and Flag	Previous Result and Date	Units	Reference Interval
Cortisol [01]	10.1 Please Note: The reference interval and flagging for this test is for an AM collection. If this is a PM collection please use: Cortisol PM: 2.3-11.9		ug/dL	6.2-19.4

ACTH, Plasma

Test	Current Result and Flag	Previous Result and Date	Units	Reference Interval
ACTH, Plasma [01]	10.1 ACTH reference interval for samples collected between 7 and 10 AM.		pg/mL	7.2-63.3

Prolactin

Test	Current Result and Flag	Previous Result and Date	Units	Reference Interval
Prolactin [01]	14.1	22.0* 12/23/2020	ng/mL	4.8-33.4

* Previous Reference Interval: (Prolactin: 4.8-23.3 ng/mL)

IGF-1

Test	Current Result and Flag	Previous Result and Date	Units	Reference Interval
▲ **Insulin-Like Growth Factor I** [03]	**295 High**		ng/mL	74-239

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701 North Broadway
Sleepy Hollow, NY 10591

Patient Name:	SONG,JULEE	Location:	PSCASU
Med Rec #:	MR00981042	Account #:	PA0009360196
Date of Birth:	05/18/1982	PCP:	DOCTOR NOT ON STAFF
Age:42	Sex: F	Attending:	Goldstein,Karli P DO

OPERATIVE REPORT
DATE OF PROCEDURE: 04/04/2025

SURGEON: Karli Provost Goldstein, DO

PREOPERATIVE DIAGNOSES: Right ovarian endometrioma, rule out endometriosis.

POSTOPERATIVE DIAGNOSES: Bilateral ovarian endometrioma, multiple and extensive endometriosis, retroperitoneal fibrosis, inflammation and adhesions and suspicious endometriosis of the appendix, ovarian adhesions, paratubal cysts, and bowel adhesions.

PROCEDURES PERFORMED: Cystoscopy with retrograde bilateral ureteral catheterization and injection of indocyanine green, hysteroscopy with dilation and curettage with chromopertubation, robotic-assisted laparoscopic excision of endometriosis, appendectomy, bilateral ureterolysis, right hypogastric decompression, rectal nodulectomy with repair, bilateral ovarian cystectomy with reconstruction, bilateral ovarian omentopexy, and rectal nodulectomy with repair.

ASSISTANT: Joanie Garcia Bradshaw, PA.

SPECIMENS: Total specimens 25. Please list them as follows.

1. Endometrial curettage for CD138.
2. Sigmoid nodule.
3. Sigmoid adhesions.
4. Left paratubal cyst.
5. Left ovarian surface endometrioma #1.
6. Left ovarian surface endometrioma. #2.
7. Right ovarian fibroid.
8. Right utero-ovarian cyst.
9. Right ovarian endometrioma. #1.
10. Right ovarian cyst wall.
11. Right ovarian endometrioma #2.
12. Left ovarian fossa.
13. Left periureter.
14. Left uterosacral plate.
15. Left uterosacral ligament nodule.
16. Posterior cervix nodule.
17. Right uterosacral ligament nodule.
18. Right ovarian adhesion.
19. Right hypogastric.
20. Right periureter.
21. Right ovarian cliff.
22. Right uterosacral plate.
23. Right rectal nodule.
24. Appendix.

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25. Left bladder.

INDICATIONS FOR PROCEDURE: The patient is a 42-year-old female who started trying to conceive at age 41. She was seen by her OB/GYN who performed an HSG, but saw a filling defect and overall the tubal patency was confirmed. She underwent hysteroscopy by an REI where she had polyp removal and she did three rounds of IVF at Cornell with varying results. She was seen to have a 2 cm hemorrhagic cyst versus endometrioma, but was never formally diagnosed with endometriosis. She had menarche age 13 and had pain for the first few days in her teenage years with dark clots. Sometimes she had shortened cycles and has rectal pain with painful constipation three times the year. She takes multiple supplements and has no known family history of endometriosis. She was offered conservative management and sent for an MRI and the MRI showed a 2.4 cm endometrioma and thickening of the left adnexa, possibly due to endometriosis. We discussed containing the fertility treatments versus removing the endometriosis and then performing further fertility treatments as necessary due to the patient's altered results of obtaining a pregnancy and normal embryos in the inflammatory environment seen with the endometrioma. She elected for surgical excision of the endometrioma.

DESCRIPTION OF PROCEDURE: She was consented for surgery and taken to OR 4, where she was administered general anesthesia. Once this was done and found to be adequate, she was prepped and draped in normal sterile fashion after anesthesia performed an ultrasound-guided TAP block . They will be dictating this portion. We then prepared her in lithotomy position. A time-out was performed. I then performed cystoscopy with a 22-French cystoscope. The bladder was entered and appeared to be slightly inflamed. Both ureteral orifices were catheterized with a 5-French open-ended catheter and 10 cc of diluted indocyanine green with sterile water were injected into both ureters without difficulty. The cystoscope was removed and a Foley catheter was inserted in the bladder for the remainder of the case.

Following this, anterior lip of the cervix was grasped with single-tooth tenaculum and the cervix was sterilely dilated to #20 Pratt dilator. The hysteroscope MyoSure diagnostic was then placed intrauterine and the cavity was visualized. Both ostia appeared to be normal. There appeared to be some excess proliferative tissue, which was gently curetted out and sent for analysis to rule out endometritis and rule out plasma cell of the CD138 staining. a HUMI manipulator was inserted in the uterus in preparation for methylene blue for chromopertubation. This was attached to the HUMI manipulator. I then changed gloves and attended the abdomen.

A small incision 8 mm in size was made at the umbilicus followed by insertion of the Veress needle. Once a low starting pressure of 3 mmHg was obtained, the abdomen was insufflated to 20 mmHg for insertion of the trocars. Using a 5 mm laparoscope inside a robotic trocar, the umbilicus was entered and the peritoneal cavity was entered without difficulty. The bowel was surveyed. There was no harm to the surrounding bowel noted. We then placed robotic trocars in the right mid quadrant and left mid quadrant. A 5mm assistant trocar was placed triangulated upwards between the left mid and umbilical trocar for laparoscopic assistance by PA Joanie throughout the case. The pressure was then lowered from 20 to 15 mmHg.

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The abdomen was surveyed. The liver was surveyed and diaphragm and the central tendon of the diaphragm appeared to be completely normal with no evidence of endometriosis here. The upper abdomen and bowels appeared to be normal. The patient was placed in steep Trendelenburg to 28 degrees and the uterus was observed. The robot was docked by PA Joanie and robotic instruments were placed under direct visualization. In arm 2, Maryland bipolar, in arm 3 camera and in arm 4 monopolar scissors.

Immediately, we noted some endometriosis bon the left ovarian surface. There also appeared to be a inguinal hernia on the right side. The right ovary was noted to be attached into the pelvic sidewall and larger than the left side. There appeared to be fibrotic endometriosis around the posterior cervix and uterine surface pulling the rectum and kinking it slightly, likely the cause of her rectal pain. The appendix was noted to be dilated and attached in multiple areas in a torturous fashion to the right psoas. Decision was made to perform appendectomy later in the case to prevent any sort of obstruction or rupture of the appendix. There was the surface endometrioma on the left side on 2 areas of the ovary and one of the surface endometrioma as the ovary noted to be contracted a little bit more here on the left. This was gently excised using cold cut technique with scissors with no energy applied to the ovary and sent to pathology. There was more chocolate cystic fluid behind the surface endometrioma and the cyst capsule was removed. The right ovary was examined. There were noted to be multiple adhesions underneath the right ovary attaching it to the pelvic sidewall.

Ovarian lysis was performed and the ovarian adhesions were gently excised off the right ovarian course. This was done also to free the fallopian tubes on both sides. We did see methylene blue passed through the right fallopian tube and some extended to the left fallopian tube after very lysis was performed. The cystectomy was performed on the right side as well by incising the area in the right ovary in first checking to see if it was chocolate cystic fluid, it was in fact very thick dark chocolate cystic fluid. This was drained and suctioned completely and some of this was sent to pathology for analysis. The ovarian cyst bed was then opened up using scissors on cold cut technique with no thermal energy at all applied to the ovary. The cyst rim was then excised and the cyst wall was enucleated using Marilyn forceps and switched the Monopolar Scissors for Prograps in arm four. The cystectomy was performed by completely enucleating the cyst walls and sending these to pathology. I then carefully repaired half of the ovary on both sides using a 3-0 Vicryl on RB1 needle and a Megasuturecut needle driver in arm four. The ovaries were gently suspended upwards temporarily in order to perform the sidewall excision of endometriosis. The sutures and needles were parked at the medial umbilical ligament.

The pelvic sidewalls were examined and endometriosis excision was performed extensively along the pelvic sidewall first in the systemic manner by mobilizing the sigmoid colon. There was noted to be nodularity and adhesions and suspicious fibrosis along the sigmoid mesentery, which is pulling the sigmoid to the left psoas. These were excised as specimen #2 and 3. All endometriosis excisions were performed using Maryland in arm 2, camera in arm 3, and robotic scissors in arm 4. There was a paratubal cyst noted on the left. This was excised and sent to pathology and the ovarian surface endometriomas were

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sent as specimen 5 in 6. There was a small fibroid noted on the right ovary, which was excised as specimen 7, and there was cystic area along the right utero-ovarian ligament, which was excised carefully as specimen #9.

The right ovarian endometriomas were noted to be two separate small portions. These were excised, enucleated and cystectomy was performed as specimen 9, which was endometrioma one, and specimen 10 which was the cyst wall, and 11, which was another right ovarian endometrioma #2. Then ureterolysis was performed on the left side and indocyanine green mode was used to toggle between regular mode and fluorescence mode to visualize the ureters safely. The left ovarian fossa was excised with endometriosis as specimen 12 and fibrosis along the course of the ureter sent as left peri-ureter #13. The left uterosacral plate was hydro-dissected and both cystectomies were performed. All the endometriosis was excised meticulously with use of hydrodissection technique, which was performed by making a small incision at the peritoneum or at the cyst wall and hydro-dissecting with irrigation fluid the spaces surrounding the endometriosis in order to prevent any injury or loss of bladder nerve supply. The left uterosacral plate and left uterosacral ligament nodule were carefully hydro-dissected off the course of the uterine artery blood supply and these were excised and sent to pathology separately. There was thickened endometriosis along the posterior cervix, which was pulling off the rectum with adhesions and this was excised. And nodulectomy performed on the right uterosacral ligament and sent as specimen #17. There was some fibrosis and kinking of the rectum along the right hypogastric plexus. This was carefully excised with no using nerve-sparing technique along the fibrotic peritoneum above the course of the hypogastric plexus. This was excised as specimen #19.

Right ureterolysis was similarly performed and suspicious endometriosis and peritoneal abnormalities were sent as specimen 20, right periureter, and 21 right ovarian cliff, which was the pouch where the ovary was resting, which appeared to be like an Allen Masters window. The right uterosacral plate was similarly hydrodissected off the course of the right uterine artery and sent as specimen #22. The rectum and rectal kink was carefully excised and had multiple pigmented areas of endometriosis along these areas. It was excised as right rectal nodule, specimen 23. There was no harm to the rectum noted, however, this area was partially denuded, therefore it was oversewn using the robotic 3-0 Vicryl on RB1 needle in three interrupted stitches. These were carefully tied intracorporeally using the megasuturecut needle driver and Maryland bipolar.

Following this, the appendectomy was performed using the vessel sealer in arm 4. The mesoappendix and the extensive adhesions around the appendix were taken down. The mesoappendix was taken down to the base of the cecum and the appendiceal artery was ligated using vessel sealer. Once the cecum and the appendix were completely mobilized and this was performed, Joanie then inserted PDS endo-loops into the assistant laparoscopic trocar and the appendix was amputated first to the base of the cecum and then two additional endo-loops, one at the base of the cecum and one approximately half a cm upwards, which were taken down. The appendix was then carefully amputated using scissors and the base was coagulated using monopolar current. This was sent to pathology as specimen #24 and removed through the robotic trocar.

The bladder was examined. There were noted to be some endometriosis fibrotic white nodule along the left bladder, which was carefully was excised as specimen 25 with no harm to the bladder. All specimens were carefully cross examined. I

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then mobilized the omentum in preparation for the omentopexy. The patient was repositioned into 20 degrees of Trendelenburg and the omentum was seen to be adequately long enough to perform an omental tongue implant into both ovaries for adhesion prevention and extra blood supply to the ovary. The omentum was divided into two using vessel sealer and each tongue was carefully sewn into the left ovary first with the robotic RB-1 Vicryl and tied intracorporeally using robotic Megasuturecut needle driver. This was repeated on the right side and excellent omental patch was noted into both ovaries.

Excellent hemostasis was noted at excision sites and reconstruction of the ovary entirely with no evidence of endometriosis was seen. Pictures were taken. Meticulous hemostasis was performed until bone dry appearance was noted using bipolar. All robotic instruments were removed under direct visualization. The robot was undocked but remained sterile. Surgical pause was performed by desufflating the abdomen for 5 minutes removing all instruments, then reinsufflating the abdomen 5 minutes later and examining all previous surgical sites. Excellent hemostasis was noted. All fluid gas clots were suctioned above the pelvis above the liver brim. The trocars were removed under direct visualization. All gas was suctioned out of the abdomen again a second time. The umbilicus was then closed with 0 Vicryl in a reverse knot manner and the smaller incision sites were closed with 4-0 Monocryl. Steri-Strips and Dermabond was applied and a 2 x 2 and Tegaderm to the central trocar site. There were no complications. Total estimated blood loss was less than 50 cc.

Dictated by: Karli Provost Goldstein, DO
KG/AQS
D: 04/06/2025 14:34
T: 04/06/2025 14:47
Dictation ID: 02208242 / 00008277

<Electronically signed by Karli P Goldstein DO>
04/10/25 1652

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Northwell Health℠

SURGICAL PATHOLOGY REPORT

Patient Name:	**SONG,JULEE**			Accession #:	**PS25-2166**
Med. Rec. #:	MR00981042	Location:	PSCASU	Collected:	04/04/25
DOB:	05/18/1982	Room/Bed:		Accessioned:	04/04/25
Age & Gender:	42 Year(s) F	Account #:	PA0009360196	Reported:	04/11/25
Admitting MD:	Goldstein,Karli P DO		Submitting MD:	Goldstein,Karli P DO	
Copy To:	DOCTOR NOT ON STAFF	;		;	

FINAL DIAGNOSIS

A. EMC CD138:
- Fragments of proliferative endometrium with rare plasma cells.
- Strips of benign endocervical mucosa.
- Immunohistochemical staining with CD138 performed and showed rare positive cells.

B. SIGMOID NODULE:
- Mesothelial lined fibroadipose tissue with fibroelastosis.

C. SIGMOID ADHESION:
- Mesothelial lined fibroadipose tissue with fibroelastosis.

D. LEFT TUBAL CYST:
- Fibromuscular tissue with ciliated (tubal type) mucosa.

E. LEFT OVARIAN SURFACE ENDOMETRIOMA #1:
- Ovarian surface with endometriosis.

F. LEFT OVARIAN SURFACE ENDOMETRIOMA #2:
- Ovarian surface with endometriosis.

G. RIGHT OVARIAN FIBROID:
- Benign spindle cell lesion, most compatible with fibroma.
- Immunohistochemical staining with desmin is negative.

H. RIGHT UTERAL OVARIAN CYST:
- Benign flat/cuboidal epithelial lined cyst.

I. RIGHT OVARIAN ENDOMETRIOMA #1:
- Detached few hemosiderin laden macrophages.

J. RIGHT OVARIAN CYST WALL:
- Ovarian tissue with endometriotic cyst.

K. RIGHT OVARIAN ENDOMETRIOMA #2:
- Ovarian tissue with endometriotic cyst and a follicle cyst.

L. LEFT OVARIAN FOSSA:
- Mesothelial lined fibrous tissue with rare hemosiderin laden macrophages.

M. LEFT PERIURETER:
- Mesothelial lined fibrous tissue with rare hemosiderin laden macrophages.

N. LEFT UTEROSACRAL PLATE:
- Endometriosis.

O. LEFT UTEROSACRAL LIGAMENT NODULE:
- Endometriosis.

P. POSTERIOR SURFACE CERVIX:
- Endometriosis.

Q. RIGHT UTEROSACRAL LIGAMENT NODULE:
- Mesothelial lined fibrous tissue with rare hemosiderin laden macrophages.

R. RIGHT OVARIAN ADHESION:
- Mesothelial lined fibrous tissue with rare hemosiderin laden macrophages.

S. RIGHT HYPOGASTRIC:
- Mesothelial lined fibroadipose tissue.

T. RIGHT PERIURETER:
- Mesothelial lined fibrous tissue with mild chronic inflammation.

U. RIGHT OVARIAN CLIFF:
- Mesothelial lined fibrovascular tissue with mild chronic inflammation.

V. RIGHT UTEROSACRAL PLATE:
- Fibromuscular tissue with marked cautery artifact.

W. RIGHT RECTAL NODULE:
- Endometriosis.

X. APPENDECTOMY:
- Benign appendix with fibrous obliteration of the tip.

Y. LEFT BLADDER:
- Endometriosis.

Comments:
- In this clinical setting, presence of hemosiderin laden macrophages not diagnostic but suggestive of endometriosis.