PELOSI MEDICAL CENTER Patient Name: _____

Cosmetic Vaginoplasty Operative Report

Birthdate: ____/____/____ MR #: _____

Date of Procedure: _____ **Surgeon/Assistant**: _____

Anesthesia/Anesthesiologist: _____

Height/Weight/Parity: ___ft___ in / _____ lbs / _____

Fluid Intake: _____ ml **EBL**: _____ ml **Drains**: ☐ None ☐ Jackson-Pratt

IV Antibiotics: ☐ None ☐ Yes _____

Pre-Operative Diagnosis: ☐Vaginal Laxity ☐ Rectocele ☐ Cystocele ☐ Other:_____
☐Primary Procedure ☐Revisionary Procedure

Post-Operative Diagnosis: Same

Procedure:
☐ Perineoplasty
☐ Colpoperineoplasty
☐ Rectocele Repair
☐ Cystocele Repair
☐ Other:_____

Condition: _____

Clinical Findings:

This is a ____year-old female with a preoperative diagnosis described above requesting elective cosmetic surgery. After a discussion of the risks, benefits and expected outcomes of the procedures described above and of all treatment alternatives, she signed a statement of written informed consent.

Description of Procedure:

☐ The patient was brought to the operating room and kept awake because she requested local anesthesia.
☐ The patient was brought to the operating room and placed under an adequate level of anesthesia.

She was then prepped and draped in the usual sterile fashion for vaginal surgery with anti-embolic stockings & sequential compression stockings applied.

The targeted dimensions of the vaginal introitus were established by careful digital assessment and surgical markings were made on the perineum. The marked tissue was injected with a dilute solution of lidocaine and epinephrine for anesthesia and hemostasis. Incisions were made using a combination of ☐ sharp dissection, ☐ electrosurgical dissection, ☐ radiofrequency dissection, ☐ CO_2 laser dissection.

A flap of perineal skin and subcutaneous fat was made and advanced to the level of the posterior vaginal wall. After mobilizing the bulbocavernosus muscles bilaterally, the posterior vaginal wall and the rectovaginal space were injected with the same local anesthetic. A triangular excision of the posterior vaginal wall was marked and the posterior vaginal wall was undermined and excised sharply. Hemostasis was achieved with ☐ absorbable sutures ☐ electrocautery ☐ other:_____.

☐ Since perineoplasty only was planned, no additional dissection was carried out and the vaginal wall incision edges were closed with a running suture of No. 2-0 Vicryl.

☐ Since colpoperineoplasty was planned, additional undermining of the posterior vaginal wall was carried out lateral and superior to the excised tissue to expose the rectovaginal fascia and the levator ani muscles. ☐ No rectocele was present. ☐ A rectocele was noted and repaired with running sutures of No. 2-0 Vicryl in ___layers with transrectal palpation throughout this process to avoid rectal wall injury. The levator ani muscles were approximated in the midline to the desired degree of tightness using No. 0 Quill in ___layers with transrectal palpation throughout this process to avoid rectal wall injury. Hemostasis was confirmed and the surgical field was irrigated with sterile saline. The vaginal wall incision edges werew closed with a running suture of No. 2-0 Vicryl.

The deep tissues of the perineal body were approximated with ☐ No. 2-0 Vicryl ☐ No. 0 Quill ☐ Other:_____ incorporating the bulbcavernosus muscles and the deep and superficial transverse perineal muscles. The skin was approximated with interrupted sutures of No. 4-0 Monocryl. Hemostasis was confirmed at all surgical sites.

A foley catheter ☐was not placed ☐was placed. Vaginal packing ☐was not placed ☐was placed. Antibiotic ointment was placed over all incision lines and vaginal packing was employed. The patient tolerated the procedure well and was brought to the recovery room in stable condition.

_____ _____
Surgeon Signature Date