2018 TAJEV / Video Presentation

[VP-001]

Ghost ovarian cyst

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In this case, the patient was referred to our polyclinic for a routine control examination of 65 years old Gravida 3 parity 3. The patient has no additional disease. Twenty years ago, there was a history of abdominal hysterectomy and bilateral salpingooferectomy for myoma uteri. The physical examination of the patient is natural. Received cuff smear pathology result normal. In transvaginal USG, the appearance of a cystic lesion that may be compatible with an 'unkiste' space of about 5 cm is observed. Due to the suspicion of Unkiste space or abdominal mass the patient was scheduled to CT. In malignancy screening and follow-up program tumor markers (AFP, CA-125, CA-19-9, CA-15-3, CEA) were within normal limits. Blood test and other routine hematological examinations and biochemical tests were within normal limits. The internal genital organs were not observed in the CT. In the Uterus log, a complex cystic lesion with soft tissue densities showing suspicious contrast in the superomedial segment of 50 mm was observed. Diagnostic L/S was planned for the patient for histopathological examination. Intraoperative First, adhesions on the anterior view of the 'unkiste' space above the bladder were removed. And the 'unkiste' space was evacuated. Intraop USG, which was made for the purpose of control, entered the right retroperitoneal area because the cystic lesion persisted in the right pelvic region. And although the patient's statement had abdominal hysterectomy and bilateral salpingo-oophorectomy, Right over was observed. Right salpingooferectomy was performed to the patient. Acquired material was taken out with the help of Endobag. It was sent to the pathological Frozen study. Negative reported for malignancy. The procedure was terminated without complications. Subsequently, serous cystadenoma was reported in the main pathology report. The postoperative period was uncomplicated and the patient left the ward in the 2th day after surgery.

Keywords: Diagnostik laparoscopy, ovarian cyst, postmenopausal period

[VP-002]

Laparoscopic multiple myomectomy

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Objective: In this video we aim to show the surgical approach, according to the size and location of the myomas, and also restoration of the myometrium with different surgical techniques on the patient that we performed laparoscopic myomectomy.

Material and Methods: The laparoscopic myomectomy was performed for the myoma uteri to the 37-years old patient who complains abnormal uterine bleeding and abdominal pain. Standardized laparoscopic procedure was performed to the patient. The patient had 3,4 and 4 cm subserosal myomas on the posterior wall and 2, 3 cm intramural myomas on the anterior wall of the uterus. The operation has started with the incision for the removal of the posterior wall subserosal myomas. Afterwards from a different incision, myomas of the anterior wall were removed. Myometrium was sutured with intracorporeal and extracorporeal stiches after myomas were enucleated. Morcellator was used to remove the myomas from the abdomen.

Results: The myomas of the patient was removed with minimum incisions. Myomas was taken from abdomen by means of morcellator. There was no complication intraoperatively. The patient was discharged on the second day of the operation. The complaints of the patient before the surgery were regressed. The final pathology was reported as beningn myomas of uterus.

Conclusion: Laparoscopic myomectomy is a quite often gynecologic procedure that is performing at the present time. The location and size of the myomas are important factors which affect the success of the laparoscopic myomectomy. While the operation, the capsule of the myoma should be find out clearly and progression should be from the convenient cleavage. Different incisions can be made to remove for the myomas which are at different localizations. In these patients, the aim should be the creation of the least number of incisions. Therefore, myomas which have close placement can be removed from the same incision. According to the depth of myometrial damage and level of incision, varied suturing techniques can be performed. In this presentation we aimed to show our clinically surgical approach to the patient who has multiple myomas.

Keywords: Laparoscopy, myomectomy, multiple myomas

[VP-003]

Laparoscopic hysterectomy following ureteral dissection

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Hysterectomy operation is the most commonly performed gynecological procedure. It can be performed both in benign and malignant diseases. It can be carried out through abdominal, vaginal and laparoscopic ways. Given the rates of morbidity and mortality, vaginal way should be the method of first choice. The latest way to be preferred should be abdominal route. In recent year, rate of the laparoscopic method has been extremely increased among the hysterectomies performed worldwide. Performing this procedure

is increasing day by day because of quick postoperative recovery, lower rate of complications, and possibility of early discharge. One of the most dreaded complications during laparoscopic hysterectomy procedure is damage to the ureter. Ureter dissection before hysterectomy increases visualization of the ureter, decreasing ureter injuries. However, it is possible to explore the ureter trace without performing dissection in patients without pelvic adhesions. In addition, damage to adjacent organs, bleeding, and ureter damage secondary to decreased ureteral vascularization may occur dissection. Therefore, there is a common opinion of that there is no need for dissection in benign cases without adhesions. We aimed to present bilateral ureteral dissection performed from the pelvic entry before hysterectomy, and then total laparoscopic hysterectomy procedure we carried out in a patient.

Keywords: Hysterectomy, laparosccopy, ureteral dissection

[VP-004]

Laparoscopic excision of cesarean scar pregnancy

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Caesarean scar ectopic is one of the rarest of all ectopic pregnancies. It is defined as when a blastocyst implants on a previus caesarean scar. The incidence of caesarean scar ectopic has increased due to increase in number of caesarean deliveries. Early diagnosis of this can be done by using sonography. We report a case of G3P2L2 with previous two caesarean deliveries, diagnosed as caesarean scar ectopic pregnancy with the help of sonography. On investigation, routine blood and urine investigations were normal. On admission B-HCG level was 6134 IU/L, and after 48 hours B-HCG value was 7304 IU/L, which showed less than doubling. Trans vaginal ultrasound revealed empty uterine cavity with clearly defined endometrium, irregular small gestational sac like structure of six week seen in lower uterine segment anteriorly with no cardiac activity. Four trocars were required for the surgery: one umbilical 11 mm trocar for the camera, two ipsilateral 5 mm trocars at left side and one 5 mm trocar at the right side of the patient. Dense bladder adhesions on cesarean scar pregnancy were carefully removed by blind and sharp dissections. After the safe margin was created, the pregnancy material was removed and the scar was repaired by suturing. The patient was discharged on postoperative day 2 without any complications.

Keywords: Caesarean scar pregnancy, laparoscopy, ectopic pregnancy

[VP-005]

Bilaterally recurren dermoid cyst laparoscopically managed on pregnancy

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Ultrasonograpy is an routine procedure for following of pregnancy. In pregnant women detected %1 -4 adnexial masses on routine ultrasound examination 1. Ninety five percent of them evaluated before 16 weeks. And ovarian cyst prevelance for 13-16 week's gestation found 8.2%. Widespread use of ultrasound has increased detection rate of pelvic masses in pregnancy. But, Location of tumor markers is infrequent while ultrasound assessment of benign malign differentiation has a great importance. Usually masses are asymptomatic. Most common symptom is pelvic pain. They may also cause pre-term labor or obstructionof labor. Furthermore, malignancy is a potential risk. Torsion of adnex is the important and emergent complication of teratomas. One in five ve adnexal torsions occurs in a pregnant woman. It occurs most frequently in the first trimester, occasionally in the second trimester (3). It is difficult to decide what to do with asymptomatic teratomas detected in pregnancy. With increasing torsion risk due to the increase in the gestational week, it is quite complicated to compensate the surgeon for risks associated with anesthesia or abdominal manuplation in pregnancy. We also aimed to describe the phenomenon of laparoscopic surgery with a safe compartment with the cause of recurrent ovarian teratoma bilaterally growing in 16^{th} gestational age. Twenty six years old, 9 weeks pregnant woman refered to our clinic. On her history, nine years ago she was operated (laparatomically cystectomy) for bilaterally mature teratoma. We determineted bilateral ovarian teratoma. Right mass was 6 centimeters, left one was 5 centimeters. At week 12, we observed 2 cm enlargement of masses and differences in internal echogenicity. We discussed with the patient and parents about malignancy and torsion riscs. They decided to surgery. Before one hour the operation we administered 500 mg Hidroksiprogesteron Kaproat intramuscularly and seftriakson 1 gr intravenously. We performed bilaterally laparoscopic cystectomy in two safety compartments. Operation surged for 60 minutes. Diet was started 6 hours after the operation. The patient discharged on 24. Hours without ant complications. Pathology resulted with bilaterally mature teratomas. Laparoscopic surgery in pregnancy becomes significantly difficult with the increase in the gestational week. The difficulty of removing the ovarian masses without touching the uterus, the ruptured and pelvic spread of a suspected cyst, brings with it additional difficulties in cases of dermoid cystectomy. If rupture occurs, massive irrigation is required to avoid chemical peritonitis risk. This may increase both the surgery time and the need for uterine manuplation. These problems can result in anesthesia exposure and increased risk of complications or abortion. Hess and his colleagues have reported that elective surgery has less morbidity than emergency laparatomy (4). Hamilton published

an increased risk of urgent operation with torsion of large 6 cm adnexal mass after 16 weeks (5). With our technique, these risks can be minimized without any additional complications.

Keywords: Pregnancy during laparoscopy, adnexal mass, teratoma

[VP-006]

Laparoscopy in a patient with Ewing's sarcoma of uterus mimicking myoma utery: A video case report

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Objective: Ewing's sarcoma/primitive neuroectodermal tumor (ES/PNET) belongs to a spectrum of neoplastic diseases known as Ewing's family of tumors. This family of tumors is usually seen in osseous sites. Ewing's sarcoma of the uerus is extremely rare. The immunohistochemical profile of Ewing's sarcoma overlaps with other malignancies like small cell carcinoma. The rarity and complex pathologic picture of Ewing's sarcoma of the uterus creates a potential for misdiagnosis.

Material and Methods: To present laparoscopic, histopathological, immunohistochemical and molecular features of a Ewing sarkoma of the uterus, which was initially interpreted as myoma. Video demonstration of the laparoscopic intervention in a patient with Ewing's sarcoma of the uterus.

Results: A 24-year-old white Caucasian woman presented with vaginal bleeding and abdominal pain. Since the patient was virgo, abdominal and rectal examination revealed limited information. Magnetic resonance examination has shown a heterogenic tumor extending from fundus to cervix uteri, which was as large as 14 cm. in its largest diameter. The tumor was initially interpreted as a degenerating myoma. A laparoscopy was performed, which has shown that the large tumor was extending from fundus uteri to upper vagina. During the incision of uterine serosa, the tumor capsule could not be clearly defined and the further dissection showed leakage of necrotic material into the abdomen. Frozen section histopathological examination revealed a tumor with small, hyperchromatic, uniform, round nuclei, with focal areas of pseudorosette formation. The preliminary pathological diagnosis was malignant small round cell tumor (MSRCT). After an intraoperative multidisciplinary consultation with the family, a total abdominal hysterectomy with bilateral salpingo-oopherectomy (TAH/BSO), pelvic, paraaortic lymphadenectomy and an omentectomy were performed by conversion to laparotomy. The tumor was found to extend from the uterine fundus to the endocervix, even dilating the cervical canal. Histopathological, immunohistochemical and molecular features have revealed a final diagnosis of ES/PNET of the uterus, stage IIB. Detailed analyses will be issued during the video demonstration. The patient underwent adjuvant chemotherapy consisting of ifosfamide, etoposide, vinchristine, adriamycine and cisplatin. The therapy continued once every 21 days for one year. She tolerated the chemotherapy well and is free of disease, one year postoperatively.

Conclusion: Frozen section during laparoscopy is of utmost importance in complicated cases. ES/PNET confined to uterus and cervix is an extremely rare entity. With early diagnosis and appropriate treatment, ES/PNET of the uterus can be a potentially curable disease. However, owing to overlapping clinical and histopathological features, the diagnosis poses a challenge to oncologists and pathologists.

Keywords: Laparoscopy, Ewing's sarcoma, PTEN, mimicking myoma

[VP-007]

Heterotopic pregnancy developed in spontaneous cycle and laparoscopic cornual resection: Case report

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Objective: Heterotopicpregnancy (HP) is co-existance of intrauterine and ectopic pregnancies (1). The incidance of HP is 1/8.000 to 1/30.000 in spontaneous cycles while it increases up to 1 in 100 in pregnancies achieved via artificial reproductive treatments (ART) (2,3). Though mostly located in fallopian tubes, HP smay be rarely localized in uterine cornual area (4). Cornual ectopic pregnancies (CEP), the least frequent type of ectopic pregnancies, are located in the intrauterine segment of the fallopian tubes (5).

Material and Methods: In this case report, we aimed to present a CEP diagnosed as a part of HP, a very rare type of ectopic pregnancy, which developed following a spontaneous cycle. A thirty-eightyears-old gravida: 4, parity: 3, patient admitted to our clinic with complaints of pelvic pain and vaginal bleeding. Transvaginal ultrasonography revealed an embryo of 6 6/7weeks with absent cardiac activity in the uterine cavity and a second embryo of 9 3/7weeks with positive cardiac activity located in the right cornual area. She got pregnant following a natural cycle. The clinical status of the patient was stable. After taking the informed consent of the patient, laparoscopic right cornual resection and dilatation and curattege of the uterine cavity were performed. The postoperative period was uneventful and the patient was discharged on the 2nd postoperative day.

Results: The incidance of HP shave been increasing in paralel to the increase in the rate of ART pregnancies. ART and the history of tubal damage are major risk factors associated with HPS.In the present case reoprt, HP developed following a natural cycle (4,6). Pelvic pain and vaginal bleeding are the most common symptoms in patients with HP. Since the complaints of the patients have been usually attributed to the intrauterine pregnancy, the diagnosis may be delayed (3). Therefore, it is important in ultrasonographic examination of the early pregnancies. CEP is a very rare type of ectopic pregnancy having a

high rate of mortality and morbidity. CEP may continue up to further gestational weeks than the other type of ectopic pregnancies and may remain asymptomatic until the rupture of pregnancy. The extensive vascularization of cornual area and delay in diagnosis may result in ruptures with massive hemorrhage, a factor contributing to the 2-5 times higher maternal mortality rates in CEP. The appearance of an uncommonly located gestational sac surrounded by incomplete or asymetric myometrium in TVUSG and 'trophoblastic blood stream pattern characterized by high velocity and low impedance' in doppler ultrasonography for unruptured CEP have high diagnostic value (7). Ultrasonography findings in our case are coherent to the literature. In the treatment, surgical method is the main way. In medical treatment, methotrexate can be applied (8). After the treatment of the case, laparoscopic surgical method was chosen due to the adaptation problems about the follow-up of the success of the treatment.
Conclusion: Although the occurance of HP in spontaneous cycle is very rare, it must be kept in mind in first trimestre pregnancies which there are hemorrhage and pain. The crucial concept in reduction of mortality and morbidity is suspicion and the early diagnosis.
Keywords: Heterotopic pregnancy, ectopic pregnancy, cornual pregnancy, laparoscopy, missed abortus, interstitial pregnancy

[VP-008]

Robotic myomectomy; removal of a huge fibroid

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Objective: Video presentation of a huge myoma removed with robotic platform. First robotic myomectomy was performed in 2004 by Advincula et al. Since that date, number of gynecologic robotic surgeries have been increased whole over the world. It has been revealed that fibroids which are larger than 8-10 cm is not appropriate for removal with minimally invasive gynecologic procedures in the literature. However, increasing numbers of endoscopic operations and requests from patients make surgeons enforce the borders. Here we present a huge fibroid which was removed with robotic platform.
Material and Methods: Acıbadem Mehmet Ali Aydınlar University, Department of Obstetrics and Gynecology. Thirty eight year old patient with a 20x22 cm fibroid was admitted to our clinic with endoscopic removal request. After a detailed information to the patient and having an informed consent, it has been decided to perform myomectomy operation via robotic platform. The operation was performed via da Vinci Xi platform (Intuitive Surgical, Inc., Sunnyvale, C), the patient card was docked centrally, three robotic arms and smoke evacuator (AirsealR SurgiQuest, Inc., CT, USA) were used.
Results: Operation time (skin to skin) was 205 min, Docking time was 6 min, Estimated blood loss (calculated with the difference between irrigation and suction) was 350 cc, 2 transfusion had been made, first gas discharge was 13 hours after the surgery, Length of hospital stay was 2 days. No complication had been occured peri-operatively.
Conclusion: Huge fibroids can be removed by robotically.
Keywords: Robotic myomectomy, huge fibroid, laparoscopic assisted robotic myomectomy

[VP-009]

Invasive molar pregnancy in rudimentary uterine horn

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Incidence of molar pregnancy is 1-3/1000 pregnancies. Invasive mole is a local invasive form of gestational trophoblastic neoplasias which is mostly seen in reproductive age and usually follows a molar pregnancy and rarely has an initial presentation. Ectopic pregnancy in rudimentary uterine horn is extremely rare and is seen in 1/100.000-140.000 pregnancies. Invasive mole has seldom been reported in ectopic localizations but not in a patient with Müllerian duct anomaly. Here we represent a case of invasive mole in a reproductive age patient with unicornuate uterus and rudimentary communicating uterine horn. Invasive mole presented initially, mimicking ectopic pregnancy. The patient underwent operative laparoscopy and resection of rudimentary uterine horn was performed. The pathology result was reported as an invasive mole. Serum β-hCG levels normalized on post-operative first month and no additional chemotherapy was needed.
Keywords: Invasive mole pregnancy, rudimentary uterine horn, ectopic pregnancy, cornual pregnancy, gestational trophoblastic tumor

[VP-010]

Retrograde and subserous laparoscopic hysterectomy in patients with deep infiltrating endometriosis and severe adhesions: A novel technique

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Objective: Pelvic pathology such as deep infiltrating endometriosis, severe adhesions from previous pelvic surgeries and endometriosis can distort anatomy and cause increased risk of injuries to adjusting organs and cause technical challenges during laparoscopic hysterectomies.

The retrograde and retroperitoneal technique we described, overcomes these obstacles, resulting a well-mobilized uterus and leads to reduced blood loss. A subserous uterine cleavage may allow a safe adhesiolysis in cases of severe adhesions between the bowels and the uterus.

Material and Methods: To present the technique of retrograde and retroperitoneal dissection to ligate the uterine artery and mobilize the uterus as the first step of hysterectomy and to show the technique of subserousal cleavage on uterine clivagel side for adhesiolysis between bowel and uterus.

Results: A 43-year-old woman was referred to our clinic due to strong pain and bowel dysfunction. She had three previous surgeries due to endometriozis, and last intervention was a failed attempt of abdominal hysterectomy three weeks prior to our surgery. We performed a laparoscopic total hysterectomy and left adnexectomy. The hysterectomy was complicated by deep endometriozis, fixating uterus and severe adhesions between bowel and fundus uteri. Therefore we changed the procedure intraoperatively and dissected retroperitoneal areas by an anterior approach. Laterly we ligated uterine arteries, desiccated and cut the uterosacral ligaments and deep parametrian tissues on both sides using bipolar diathermy (LigaSure™ 5 mm Blunt Type Covidien). As the uterus was comfortably mobilized and its blood circulation ceased, we performed further adhesiolysis by choosing a subserous cleavage on uterin fundus, which enabled us to avoid bowel injuries. No complication was occurred during further steps as well as the postoperative period. The patient was discharged on second postoperative day.

Conclusion: Retrograde and retroperitoneal technique for laparoscopic total hysterectomy in selected patients is a safe and effective procedure. In patients with severe adhesions, a subserous cleavage may help to avoid bowel injuries or conversion to laparotomy.

Keywords: Endometriosis, laparoscopic hysterectomy, retrograde hysterectomy, subserous cleavage, adhesiolysis, conversion to laparotomy

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[VP-011]

Laparoscopic repair of a symptomatic post-cesarean section isthmocele: A video case report

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Objective: Cesarean scar defects are commonly found on ultrasound examination (24%-88%). Their presence could be asymptomatic or related to postmenstrual spotting, postmenstrual bleeding, or infertility. Hysteroscopic repair of a cesarean scar defect or isthmoplasty is associated with some improvement in uterine bleeding and infertility. The efficacy of laparoscopic repair seems to be superior to hysteroscopy. To describe the technique for laparoscopic management of post-cesarean section isthmocele.

Material and Methods: A 35-year-old patient with a history of a previous cesarean delivery was admitted to clinic with menometrorrhagia, persistent postmenstrual spotting and chronic pelvic pain. Under transvaginal ultrasound examination, a cesarean scar defect of 10x30 mm was identified.

Results: Isthmocele diagnosis was revealed by hysteroscopy. The dehiscence seemed to stretch through the whole cesarean scar and the isthmocele seemed to be filled with whitish necrotic scar tissue, that was firmly connected to myometrium. It was not possible to fulfill the treatment hysteroscopically. The laparoscopic procedure initiated by a cautious mobilization of the bladder from its adhesions with the site of the previous cesarean scar. Subsequently, the isthmocele site was identified. The necrotic tissue, filling the ısthmocele, was gently removed. After its excision, reddish healthy myometrium was visualized. Finally, the myometrial repair was performed with the use of a double layer of continious sutures (The V-Loc™, Covidien). Operation time was 40 minutes. No complication occurred and the patient was discharged on postoperative day 1. At 90-day postoperative follow-up, transvaginal and transabdominal ultrasonography showed complete anatomic repair of the uterine defect. At 9-month follow-up, the patient reported resolution of menstrual abnormalities and chronic pelvic pain.

Conclusion: Laparoscopic repair is an effective tool for treatment of large post cesarean scar defects and is superior to hysterectomy.

Keywords: Laparoscopic repair, post-cesarean section isthmocele, case report

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[VP-012]

A novel technique for laparoscopic myomectomy in patients with large fibroids: Tightening the inner running suture after final layer sutures

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Objective: Laparoscopic myomectomy may cause intra- and postoperative complications in patients with large uterine fibroids, due to strong bleeding, dead space formation, postoperative bleeding or suboptimal healing in myometrium. We have established a new technique for laparoscopic myomectomy to solve these issues by a final tightening of the inner layer of running suture. This report evaluates the results of this technique used in ten patients with uterine fibroids >10 cm.

Material and Methods: To demonstrate a novel surgical technique and to evaluate the data of ten patients with large fibroids who had laparoscopic myomectomy and final tightening of the inner running sutures. Outcome criteria were conversion to laparotomy, operation time, need for blood transfusion, postoperative bleeding requiring secondary surgery, evidence of dead space formation by ultrasound. Subjects, material and surgical technique: Laparoscopic myomectomy was performed in a standard manner in ten patients with uterine fibroids ranging 10 to 17 cm in diameter. The procedures

were performed between January 2017 and January 2018. A multilayered running suture technique was used after laparoscopic myomectomy by V-Loc™ wound closure device (3.0 sutures, 26 mm needle, 15 cm, Covidien). The V-Loc™ wound closure device is absorbable in 180 days and supports optimal soft tissue approximation without any need to tie knots. V-Loc™ devices utilize a dual-angle-cut which creates an anchoring barb while optimizing the strand's integrity. However the approximation of the wound edges after removal of large uterine fibromas may cause difficulties in the inner layer due to tissue tension. Thus the free end of the inner running suture was led through the myometrium out of the incision area to adjust the wound approximation. After the final layer of running suture, the free end of the inner layer was pulled to enhance the approximation tension in the inner layer. The fibroids were removed by standard morcellation tecnique.

Results: There were no conversions to laparotomy. Mean operation time was 105 minutes (70-170 minutes). Once the bleeding was under control by final tightening of the inner running suture no patient required intra- or postoperative blood transfusions or secondary surgery. Postoperative ultrasound examinations revealed no dead space formation within the uterus.

Conclusion: Our experiences show that self-anchoring sutures need a final adjustment in surgeries with increased tissue tension, such as myomectomy. The final tightening of the inner running suture after myomectomy supports adequate wound approximation and may reduce the risk of postoperative bleeding, dead space formation and support optimal wound healing in patients with large uterine fibroids.

Keywords: Laparoscopic myomectomy, wound closure device, approximation, tightening

[VP-013]

Laparoscopic resection (shaving) of deep pelvic endometriosis with rectal

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Deep endometriosis is one of the most complex and risky surgeries. Its laparoscopic management requires a sysematic approach, a good anatomical knowledge, and a high level of surgical competency. In this video, we present a clinical case of a 33-year-old woman with deep pelvic endometriosis. She had a long history of severe dysmenorrhea, dyspareunia, colicky abdominal pain, back pain. On bimanual examination, a 3x3 cm nodule was palpated. Transvaginal ultrasonography confirmed the fibrotic endometriotic nodule extending from the rectum to uterine posterior wall. This patient had a caesarean section 5 years ago. After dienogest therapy, the patient was operated on due to chronic pain. Four trocars were required for the surgery: one umbilical 11 mm trocar for the camera, two ipsilateral 5 mm trocars at left side and one 5 mm trocar at the right side of the patient. Adhesiolysis of the sigmoid colon and the mesosigmoid was started, with the assistant retracting the bowel at 90 degrees until pelvic landmarks, major vessels, and the ureter (left behind) were identified. The tissues were very thick and adherent to the left pelvic wall. Medially to the ureter, in the pararectal space, the peritoneum was partly released and opened. The pelvic spaces are dissected in order to see the endometriotic nodule and the urinary structures. The endometriotic fibrotic tissue was adherent to the rectum. The large fibrotic nodule was shaved from the rectum. We placed one abdominal drainage to the Douglas pouch. The oral intake was introduced on postoperative day 2 with a good tolerance and the patient was discharged on postoperative day 4 without complications.

Keywords: Laparoscopy, endometriosis, deep pelvic endometriosis

[VP-015]

Robotic and laparoscopic sentinel lymph node mapping in endometrial cancer and proposal for NCCN SLN algorithm

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Objective: Although high detection rate with indocyanine green/near-infrared fluorescent technology (ICG/NIR) has been reported, bilateral mapping was not achieved in approximately 20-25% of the cases and side specific systematic lymphadenectomy should be performed for these cases according to the SLN algorithm. The aim of the present study was to evaluate extrapelvic sentinel lymph nodes in clinical early stage endometrial cancer patients with unmapped pelvic side(s) during fluorescent imaging-based sentinel mapping.

Material and Methods: Eligible patients underwent to sentinel mapping using cervical injection of indocyanine green and near infrared florescent imaging compatible endoscopic systems. Pelvic sentinel lymph nodes were identified and resected. If bilateral mapping was not achieved, upper lymph nodes areas including presacral, upper common iliac, and para-aortic-caval regions were explored for any sentinel lymph node. Systematic lymphadenectomy was performed after applying sentinel lymph node algorithm steps.

Results: In 24 of 101 patients bilateral pelvic mapping was not achieved. Bilateral unmapping was seen in 4 of 24 and unilateral pelvic side mapping in 20 of 24 patients. There was no extrapelvic sentinel lymph node among 4 cases with bilateral pelvic unmapping while 8 of 20 (40%) patients with unilateral pelvic mapping had extrapelvic sentinel lymph nodes. Five of extrapelvic sentinel lymph nodes were in presacral, 2 in upper common iliac and 1 in paracaval regions.

Conclusion: Observing for extrapelvic sentinel lymph nodes in cases with unmapped pelvic side(s) could increase detection rate of sentinel lymph node mapping in clinical early stage endometrial cancer.

Keywords: Endometrial cancer, extrapelvic, mapping, sentinel

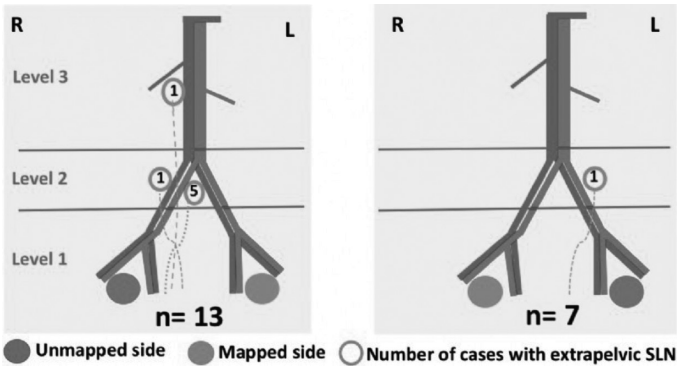


Figure 1. Flow diagram of the study

[VP-016]

Laparoscopic radical hysterectomy

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Radical hysterectomy involves removal of vagina from 1/3 to half of the vagina with parametrium. The pelvic anatomy must be well known to perform this procedure. Ureter, bladder and rectum dissection should be performed well. It is necessary to pay attention to venous bleeding from the pelvic sidewall, especially where the ureter and the urinary bladder meet. According to International Federation of Gynecology and Obstetrics (FIGO), radical hysterectomy can be performed in Stage 1B to Stage 2A cervical cancer. Radical hysterectomy can be performed as laparotomy, laparoscopy, laparoscopic assistant robotic, or robotic. In the laparoscopic method, the recovery time of the patient is shorter and the amount of bleeding is less, and good vision is obtained in the laparoscope. The patient in the video that we are going to present is at the age of 27, 80 kg, and has no additional disease. She was G4 P4. At the vaginal examination of the patient, a mass lesion of approximately 3x3 cm surrounding the anterior and posterior parts of the cervix has been observed. Biopsy result was reported as a squamous cell carcinoma. The parametrium was free in the rectovaginal examination. No additional features were observed in the MR review. The patient was considered to be FIGO stage 1B1 and it has been decided that the patient should undergo laparoscopic radical hysterectomy and pelvic lymphadenectomy. The patient was discharged on the 3rd day postoperatively. Patient's pathology tumor diameter is 3x3x2.5 cm and it is attached to vaginal mucosa 4 cm in length from the posterior fornix, 3 cm in length from the anterior fornix. Surgical margins of the vagina are tumor negative. No metastases were detected in 21 pelvic lymph nodes. Lymphovascular invasion was observed in the parametrium, tumor was seen on one lymph node in the left parametrial region. The oncology clinic was interviewed to receive chemoradiotherapy for the tumor on one lymph node in the left parametrial. No recurrence or ant other complications were observed in the control of the patient who was operated 1 year ago.

Keywords: Laparoscopy, radical hysterectomy, cervix Ca

[VP-017]

A big cervical and intraligamentary myoma: Laparoscopic myomectomy and removal from vagina without morcellation

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Objective: To demonstrate the feasibility of laparoscopic management of a big cervical and intraligamentary myoma without morcellation.

Material and Methods: Herein we present a 36 years old gravida 3 parity 3 patient diagnosed with 10 cm myoma uteri located on the right side of cervix uteri and major component of the mass was in broad ligament according to the ultrasonography. She had dysparonia and desired fertility sparing surgery. During laparoscopy, right ureter was identified clearly and a transverse incision was made over the myoma using a monopolar cautery, myoma was enucleated from uterus. After enucleation, myoma was removed from vagina by posterior colpotomy and hemostasis was provided by suturing visceral peritoneum and colpotomy incision. The patient was discharged at first day postoperatively. Her follow up was uneventful.

Results: Time of surgery was 112 minutes. Estimated blood loss intraoperavtive was approximately 200 mL. Preoperative hemoglobin level was 12 gr/dL and postoperative first day 10.9 gr/dL. Weight and size of myoma was measured 162 g and 9 cm respectively. Final pathologic result is bening fibroid.

Conclusion: Laparoscopy is a feasible and safe surgical method for management of big myomas in difficult locations such as cervical and intraligamentary region. Colpotomy posterior is an alternative route for removal instead of morcellation even in large myomas.

Keywords: Myoma utery, laparoscopic myomectomy, colpotomy posterior

[VP-018]

Hysterosalpingo-foam sonography for office tubal patency testing

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This video was demostrated to describe the effectivity with hysterosalpingo-foam sonograpy as a office procedure for tubal patency testing.

Keywords: Fallopian tuba patency tests, infertility, hysterosalpingography

[VP-019]

Laparoscopic sacropexy in vaginal vault prolapse

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This video presents laparoscopic sacropexy operation in vaginal vault prolapse. A 58 years old postmenopausal women admitted to our center with the complaint of discomfort and urinary incontinence. Thirteen years ago she had vagınal hysterectomy because of benign causes. In her pelvic examination total vagınal vault prolapse is detected.

Keywords: Laparoscopic sacropexy, vaginal vault prolapse, endoscopic surgery

[VP-020]

Vaginal reconstruction with signoid colon flap in a patient with Mayer-Rokitansky-Küster-Hauer syndrome

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Mayer-Rokitansky-Küster-Hauser syndrome (MRKH) presents in 1/4000-1/10000 women who had no congenital uterus and vagina development. Ovaries of these women are normal, and have normal functions. However, uterus and 2/3 upper vagina of these women have not developed. Therefore, these patients are primary amenorrheic. Thus, this condition can be diagnosed in the examination usually performed upon amenorrhea in girls at the times were they had their first menstruate. Some of these patients are diagnosed only when they do not have sexual intercourse when they get married. Occasionally, marriage of such patients is compromised. Therefore, reconstruction of a vagina that will enable a normal sexual intercourse in married women or those with a plan for marriage is the primary treatment. Our patient was 24 years old and married for one year. She presented to our outpatient clinic due to not having a normal sexual intercourse since she got married. In the examination and imaging performed, we found that uterus and 2/3 of the vagina were agenesic. Urinary system examination was normal. We discussed with the patients and decided to reconstruct a neovagina. Umbilical median incision was made. Orifice which will connect the flap that will be created in the retrovesical area, to the perineum was opened. A sigmoid colon flap was constructed spearing the vascularization. The distal end was anastomosed to the perineum. The proximal portion was closed and fixed to the anterior side of the sacrum. Following colon re-anastomosis, the operation was terminated. The flap maintained its viability postoperation. No complication was developed. The patient was allowed to have active sexuality one month after the operation. Both the patient and her spouse stated that they were satisfied with sexual intercourse they have experienced. Different treatment options can be used in reconstruction of a neovagina. These methods can be classified as surgical and non-surgical techniques. Non-surgical methods are the techniques requiring long duration and having probability of failed therapy and re-closure of the vagina. Therefore, we applied the surgical method in our patient. Among these methods, we used to reconstruct a vagina from intestines of the patient herself, which is the closest to the natural structure, and has natural lubrication. One of the most important problems with this method is the use of intestines which is a vital organ, and complications that may be seen with intestinal resection and re-anastomosis. In addition, since intestinal lumen has natural secretion, vaginal discharge is more than normal. However, this is decreased over time. Another important long term complication is probability of the development of malignancy from the flap mucosa. This method enabled to harvest ovaries through the vaginal route in our patient. Therefore, we paid the way for the patient to have a child using a surrogate mother. This method can be safely used in patients who desire to have a child in future.

Keywords: Mayer-Rokitansky-Küster-Hauser syndrome, sigmoid colon, vaginal reconstruction

[VP-021]

Total laporoscopic hysterctomy in eight steps

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Objective: Laparoscopic hysterectomy is common procedure in the gynecological surgery, in order to perform safe and easy surgery, surgeons reguire adequite training as well as therotical knowladge in this lecture safe and easy aproach for perfect Laparoscopic hysterectomy was demostrated in eight key steps: To perform safe and comfortable surgery, reduce post opereative pain and dis ability time, reduce the bleeding in operation.

Material and Methods: Rumi 2 uterin manipulator was placed in the uterus and veress needle tecnique was performed. After first entry of trocar intra umblically, 10 mm telescope was intrduced in the same point and two more 5 mm trocars were placed in lateral magrin of rectus muscle. The patient was placed in a trendelenburg position in

order to has a beter exposure the pelvic and abdominal organs were carefully examined.

Results: First step: Sealing and division of round ligamets. After identification of the anatomical landmarks both round ligamets were cuagulated and divided as a first step. Second step: Sealing and division of uterine pedicles two tubes and ovary proprium ligaments were cuagulated and divided. Third step: Dissecting Anterior leaf of broad ligament. Anterior leaf of broad ligament was dissected and vesicovaginal space was isolated with careful movemets the uterin manipulator was essantial in this step the uterus was strongly pushed cephaleted to prevent bladder injury the limit of dissection was showed by uterin manipulater's valve. Fourth step: Dissecting posterior broad ligament. Posterior leaf of broad ligament was dissected above the serviks and sacrouterine ligaments. Fifth step: Sealing and section of uerine artery and veins. The uterin manipulator and uterus were strongly pushed cephaleted to prevent injury to the ureter Uterine pedicules were dissected and skeletonized and sealed and divided safely. Sixth step: Performing Colpotomy. Uterine manipulator Rumi 2 helps identifying structures and finding anatomical landmarks such as vaginal fornixes for colpotomy and it also prevents the complications by pulling the ureter away from the operating field. Seventh step: Closing vagina. The vagina was closed using a multiflament absorbabale suture by vaginallly in order to prevent evissaration. Eighth step: Inspecting for bleeding. The hemostasis was controlled. Aspiration and irrıgation were made. The ovarian pedicules were checked.

Conclusion: In this tecnique using uterine manipulator rumi 2prevents the complications by pulling away the ureters from the operative field and seals the uterine pedicles away from the ureters so it makes operation safer and easier.

Keywords: Laparoscopic hysterectomy, uterine manipulator, 8 key steps

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[VP-022]

Cesarean hysterectomy with minimal bleeding using bipolar scissors in a patient with placenta percreta

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Objective: Placenta accreta is characterized by invasion of the placenta into the myometrium and serosa, and rarely into the organs such as bladder and urethra. Obstetric hemorrhage from placenta accreta has become the major cause of maternal mortality and morbidity in recent years.

Material and Methods: The most common risk factors of placenta accreta are especially cesarean section, and previous uterus surgery, and placenta previa. Probability of placenta accreta increases as the number of cesarean section increases. Placenta accreta is one of the most serious causes of postpartum hemorrhage, and its incidence is gradually increasing in recent years. When postpartum placenta accreta is attempted to be removed from where it attaches to the placenta, it causes abundant hemorrhage resulting in diffuse intravenous coagulation, renal failure, and maternal mortality. In addition, the most important causes of morbidity due to placenta accreta include especially peripartum hysterectomy, intraoperative injuries of adjacent organs such as bladder, ureter, and intestines, blood and blood products transfusion, and relaparotomy. Management of placenta accreta can be carried out in 3 ways; manual removal of the placenta (extirpative method), keeping the placenta intact without any intervention (conservative method), and cesarean hysterectomy.

Results: Cesarean hysterectomy is a surgical procedure, which may lead to abundant bleeding by itself such as placenta accreta. In recent years, studies have focused on the techniques reducing intraoperative bleeding. Some of these techniques includes preoperative angiographic embolization of the internal iliac veins, insertion of transient balloon catheters, and bulldog clamp application.

Conclusion: In recent years, vessel-tissue sealing and cutting tools powered by bipolar electrical energy are more commonly used in our clinic both in open surgeries and laparoscopic surgeries. According to our personal observations, we believe that amount of bleeding, need for transfusion, operational time, and length of stay in hospital are lower with the operations performed utilizing these tools. Therefore, we aimed to share our experience in a such operation with our colleagues.

Keywords: Cesarean hysterectomy, minimal bleeding, placenta percreta

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[VP-023]

Uterus sparing surgery using various hemostatic methods in a patient with placenta accreta

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Placental insertion anomalies are characterized by invasion of the placenta into the myometrium and serosa, and rarely into the organs such as bladder and urethra. Obstetric hemorrhage from placenta accreta has become the major cause of maternal mortality and morbidity in recent years. The most common risk factors of placenta accreta are especially cesarean section, and previous uterus surgery, and placenta previa. Probability of placenta accreta increases as the number of cesarean section increases. Placenta accreta is one of the most serious causes of postpartum hemorrhage, and its incidence is gradually increasing in recent years. When postpartum placenta accreta is attempted to be removed from where it attaches to the placenta, it causes abundant hemorrhage resulting in diffuse intravenous coagulation, renal failure, and maternal mortality. In addition, the most important causes of morbidity due to placenta accreta include especially peripartum hysterectomy, intraoperative

injuries of adjacent organs such as bladder, ureter, and intestines, blood and blood products transfusion, and relaparotomy. Management of placenta accreta can be carried out in 3 ways; manual removal of the placenta (extirpative method), keeping the placenta intact without any intervention (conservative method), and cesarean hysterectomy. Uterus sparing surgery can be performed in the cases where the depth of placental invasion is low (placenta accreta), placenta reaches to the serosa, but this area is limited, if one desires to maintain fertility. Herein, we aimed to share our experience on uterus sparing cesarean operation in which we controlled the bleeding with primary suturing, bilateral uterine artery ligation, and Bakri® Balloon application with our colleagues.

Keywords: Placenta accreta, postpartum hemorrhage, uterus sparing surgery

[VP-024]

A new compression suture technique in uterine atony treatment: Modified hayman suture

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Severe postpartum hemorrhage (PPH) is a major cause of maternal mortality and morbidity, and is increasing in incidence worldwide. Uterine atony is the commonest cause for PPH that accounts for 80% of the cases. If the initial management of controlling hemorrhage (fundal massage, uterotonic drugs) is not effective, secondary interventions (uterine tamponade procedures, compression sutures, artery ligation, embolisation and hysterectomy) should be considered. Uterine compression sutures may be effective in controlling PPH in these conditions as an alternative to hysterectomy, especially if the patient has a desire to fertility. Hayman suture technique is a simplified approach to uterine compression sutures that offers the advantages of being easier, can be applied faster, and avoids the need to perform a lower segment hysterotomy when PPH follows a vaginal delivery. The most common complications of compression sutures are uterine synechia and myometrial necrosis, which are caused by too much squeezing of sutures and left in place for a long time. In this technique we tried to reduce this complications. A 22 year old, gravida 2 parity 1 patient was admitted to our emergency clinic with massive vaginal bleeding and pain at 32 weeks of gestation. On examination her uterus was contracted and tender without cervical dilatation. Abdominal ultrasonography evaluation revealed an in utero mort fetus and a retroplacental hematoma. The patient was taken to the emergency surgery in consideration of the placental abruption. In exploration of abdomen couvelaire uterus sign was present. Cesarean section was performed with low segment transverse incision. After the delivery of the fetus, placenta was found to be total detachment. Uterus was atonic and bleeding diffusely. Continuous fundal massage and high dose uterotonics used to improve uterine tonicity without any improvement. After that bilateral uterine, ovarian and hypogastric artery ligation were performed, respectively. On the continuation of the bleeding, compression suture was placed as the last chance before hysterectomy. In this case we modified the hayman compression suture and compressed the uterus by fixing to the anterior wall of the abdomen. We taking the sutures out of the abdomen both sides and ligated it on the skin. Sutures were taken from the skin at postoperative 36th hour after the patient's postoperative vital findings were stable and there was no vaginal bleeding. Hysteroscopy was performed at 3 months postoperatively and intrauterine adhesion was not observed. In order to reduce complications, modified hayman sutur can be applied as an alternative to other compression sutures and has been found effective in stopping the uterine bleeding.

Keywords: Modified hayman suture, postpartum hemorrhage, uterine atony

[VP-025]

Laparoscopic cervical cerclage: Video presentation

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Transabdominal cerclage was first reported in 1965 by Benson and Durfee. Since then advances in the field of minimally invasive surgery resulted in development of laparoscopic cerclage. Laparoscopic technique offers the benefit of reduced blood loss, reduced postoperative pain, and fewer adhesions, as well as decreased length of hospital stay and overall faster recovery time. In this video presentation, we present the technique of prophylactic (interval) laparoscopic cerclage. The operative laparoscopy was uneventful and a No: 1 Prolene suture (Ethicon, New Brunswick, NJ) was placed at the cervico-isthmic junction above the level of the uterosacral ligaments. The patient was discharged 24 hours after surgery with no complications. Laparoscopic cerclage is considered a second-line treatment for cervical incompetence whenever vaginal cerclage is inappropriate or has failed. Primary indications are a congenitally short or absent cervix, previous cervical surgery and especially if previous vaginal cerclages have failed.

Keywords: Laparoscopic surgery, cervical cerclage, habitual abortus

[VP-026]

Robotic hysterectomy and bilateral salpingectomy in patient with CIN 3 severe adhesion between uteru and bladder due to previous gynecologic surgery

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Thirty eight years old G2P2, smear result HG-SIL, cervical conization is CIN 3 with endocervical gland involvement. The patient had previous myomectomy and cystectomy via laparotomy and laparoscopic cholecystectomy history.

Keywords: Robotic hysterectomy, adhesion, CIN 3

[VP-027]

Management of cervical adeno cancer with laparoscopic type C2 hysterectomy

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Thirty four years old virgin women patient complain with abnormal uterine bleeding. We suggest her for no touch office hysterescopy and vaginoscopy, we got her permission for defloration of her hymenal ring. Protruding polipoid mass was seen in cervical canal during hysterescopy. Punch biopsy were performed. The byopsies pathology results were endometriod type endocervical adeno cancer. MRI showed that the mass size was 25 mm and no extracervical invasion no metastatic lymph nodes and no extra pelvic metastasis. Clinal stage of tumor was 1B1. Laparoscopic type C2 hysterectomy and plevic-paraaortic lymph node dissection was performed. She was discharged after 3 days of operation day. There was no early complication. In the one year of follow up no reccurens of the diseases no long term complication no abnormal blood tests.

Keywords: Cervical cancer, type C2 hysterectomy, laparoscopy

[VP-028]

Ovarian transposition in locally advanced cervical cancer

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To demonstrate step-by-step ovarian transposition. Ovarian transposition is performed for fertility sparing or prevent early menopause in reproductive aged women who are undergoing pelvic or low abdominal radiation therapy and who will not be treated with gonadotoxic chemotherapy. In patients who are not already undergoing laparotomy for primary treatment of their disease, laparoscopy is the preferred approach and allows early initiation of radiation therapy. Complications of ovarian transposition are rare and include reports of injury and torsion of the ovarian blood vessels resulting in vascular ovarian injury, chronic ovarian pain, and infarction of the fallopian tube. As in this video will be demonstrated laparoscopically. Laparoscopic ovarian transposition has low complication rates and ovarian function is preserved in most patients.

Keywords: Transposition, cervical cancer, laparoscopy, fertility sparing

[VP-029]

Laparoscopic removal of adnexa via posterior colpotomy and laparoscopic suturing of colpotomy

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Posterior colpotomy is not routinely used to retrieve tissue from abdominal cavity unless hysterectomy is performed. However tere are some reports in the literature that describes this simple and usefull technique to remove specimens outside the abdominal cavity. In this video we present a 36 years old patient with 2 previous cesarean section who admitted to our hospital wtih the complaint of lower abdominal pain. In her ultrasound examination; a complex right ovarian cyst with malignancy suspicion is revealed. Tumor markers were within normal range. We performed laparoscopic right salpinghoopherectomy with the diagnosis of sympthomatic

complex ovarian cyst. After devascularization and removal of adnexa is held by the help of bipolar cautery and harmonik scarpel. We put the adnexa into a safebag to avoid spillage in the case of rupture. After that we performed an incision to posterior upper wall of vagina. Adnexial tissue in the safevag is retrieved easily via the posterior colpotomy incision. Contrary to the most of reports in the literature we repaired the colpotomy incision laparoscopily but not vaginally. Patient is discharged the day after operation without any problem. On her postoperative control colpotomy incision was clear wtihout sign of infection or hemorrhage. Pathology report of ovarian cyst was compatible with thecoma.

Keywords: Posterior colpotomy, ovarian cyst retrieval, laparoscopic colpotomy

[VP-030]

Fetoscopic tracheal occlusion for treatment of severe left-sided congenital diaphragmatic hernia

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Congenital diaphragmatic hernia (CDH) leads to significant neonatal morbidity and mortality due to its prenatal impact on lung development. Fetoscopic tracheal occlusion is a procedure performed percutaneously with ultrasound-guided uterine access and fetoscopic deployment of a detachable tracheal balloon with the objective of promoting fetal lung growth. Our video presents a case of severe left-sided CDH that underwent minimally invasive and reversible fetoscopic tracheal occlusion (FETO) with a balloon, survived after birth and underwent postnatal surgical repair. Twenty three-year-old, gravida 2 para 1, was referred at 29 weeks for suspected CDH. A left-sided CDH was confirmed on ultrasound, with intrathoracic herniation of liver, bowel and stomach. The observed to expected lung to head ratio (O/E LHR) based on the maximal perpendicular dimensions of the contralateral lung was 19%, consistent with a severe CDH. No other fetal anomalies were identified. Amniocentesis revealed a normal male karyotype. After informed written consent, FETO was successfully performed at 29 weeks. Postoperatively, right lung size and O/E LHR increased significantly to 52.9% on second week postoperatively. The patient developed preterm labor at 35 weeks gestation, and delivered a live male newborn 2800 g by c/s. Fetoscopic tracheal occlusion is feasible and may be a useful adjunctive prenatal therapy to improve the outcomes of fetuses with severe left- sided diaphragmatic hernia.

Keywords: Congenital diaphragmatic hernia, fetoscopic tracheal occlusion, fetal surgery

[VP-031]

Robotic sacrohysteropexy in a young patient with uterine prolapse

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To demonstrate surgical treatment of uterine prolapse in a young patient who wants her uterus to be preserved. Robotic sacrohysteropexy. A 32 year old para 2 patient who presented with third stage uterine prolapsus 1 year after vaginal delivery of a 4000 gr fetus underwent robotic sacrohysteropexy. During the operation, the rectosigmoid colon was reflected to the left to expose the presacral area. The peritoneum over the sacral promontory was incised and bluntly dissected caudally. Ureters were securely observed to prevent damage. The vesico-uterine peritoneum was incised. The uterus was erected and the broad ligaments on each sides were opened from the posterior aspect above the levels of uterine vasculature, then the uterus bended posteriorly to open the peritoneal windows anteriorly on each side at the level of the cervico-uterine junction A prolene mesh was introduced through windows created in the broad ligaments and was sutured anteriorly over the cervix. Mesh was sutured to the sacral promontory under moderate tension to achieve adequate elevation of the uterus and mesh arms were adjusted according to the need of uterine suspension by lifting the cervix at least 10 cm above the level of introitus from the vaginal way. After peritonization of the mesh material, the operation ended with adequate hemostasis. For patients with uterine prolapse but who also want uterine preservation, there are several operations using either a vaginal or an abdominal approach. Transvaginal operations are well defined in the literature but are associated with high complication rates. Among abdominal operations, sacrohysteropexy is a promising technique that yields a satisfactory anatomic and functional results with normal vaginal axis. We also believe that laparoscopic sacrohysteropexy is a safe and effective procedure in selected patients.

Keywords: Robotic sacrohysteropexy, uterine prolapse, urogynecology