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Video Posters

ENDOMETRIAL ABLATION

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Office Endometrial Ablation Using the Hydrothermal Technique

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The object of this video is to demonstrate the technique of doing hydrothermal ablation in the office setting without using IV sedation. This video shows how well tolerated this technique is. The patient is given ibuprofen 800 mg four times the day prior to the procedure, misoprostol 200mcg the night prior to the procedure, diazepam 10 mg upon leaving the house. On arrival at the office she is given, IM ketorolac 30 mg, nasal butorphanol one spray, and sublingual ondansetron 8 mg. The video shows the technique of performing hydrothermal ablation. The results of this video demonstrate that this patient was comfortable for the entire procedure. Also that the above medications combined with local mepivacaine given by the Glasser protocol was more than adequate to perform this procedure in the office. This video also demonstrated that office hydrothermal ablation is a safe and viable option to offer our patients.

ENDOMETRIOSIS

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Rectal Endometriosis: Case Report and Literature Review

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Endometriosis is an enigmatic disease that mainly affects women of reproductive age. Its etiology is not known exactly but there are many theories referred, none of which fully explains the disease. There are three types of presentation of endometriosis: peritoneal, ovarian and infiltrating. The latter is characterized by the invasion of the lesion histopathology more than 5 mm below the peritoneal surface and is considered responsible for the chronic pelvic pain, whose severity was correlated with the depth of invasion. This case of a 31-year-old with a history of infertility failures to assisted reproduction of high complexity, hematoquezia, severe pelvic pain; it was realized a total laparoscopic hysterectomy, and resection of rectal wall endometriosis; currently the patient with a significant improvement pelvic pain without hematoquezia. The management of endometriosis infiltrating deep must be with surgical excision.

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Prevention and Management of Vascular Complications in Endometriosis Surgery

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Excisional surgery for moderate to severe endometriosis may carry the risk of severe intra-operative hemorrhage. While the incidence of catastrophic bleeding is uncommon, this inherent risk may be related to the sites and severity of the endometriotic lesions and may lead to a need for conversion to laparotomy, or increase the risk of injury to pelvic organs such as the ureters and rectum in the process of gaining hemostasis. This video presentation will discuss and demonstrate preventative and therapeutic measures which may be encountered in the process of laparoscopic excision of a large ovarian endometrioma and excision of deep infiltrative endometriosis involving the pelvic sidewall, cul-de-sac, ureter and iliac vessels.

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Laparoscopic Management of Diaphragm Endometriosis

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A 25-year-old woman presented with severe dysmenorrhoea, chronic pelvic pain, dyspareunia, defecation pain and infertility. She also presented right shoulder pain during menses, which had begun one year before. MRI revealed several lesions located in the Douglas pouch, on the right ovary and on the surface of the right liver lobe. Laparoscopy showed bilateral diaphragmatic, ovarian, pelvic peritoneal, and recto-sigmoidal endometriosis. Two diaphragmatic lesions were excised and the others were coagulated. Peroperatively right pneumothorax occurred and was managed by right thorax catheter insertion and maximal lung inflation. The diaphragm was then sutured. Pelvic endometriosis was treated by excision or electrocoagulation. Postoperatively, right pleurisy occurred on day 2 and was managed by right chest drainage during 48 hours. The patient discharged day 8. She underwent GnRH agonist followed by continuous contraceptive pill intake for ten months. Twenty three months following the surgery she is free of shoulder pain.

ENDOSCOPIC COMPLICATIONS

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Segmental Ureteral Resection and Termino-Terminal Anastomosis

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On the video we show a 24-year-old patient, who has suffered a Ureter lesion after a laparoscopic oforectomy. We first recognized the injury and prepared it so we can suture it with 4 stitches of vycril 5.0 and finally we insert a ureter double j catheter and an abdominal drainage.

ENDOSCOPIC TECHNIQUES

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Laparoscopic Ureteral Reconstruction in Gynecology

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Ureteral reconstuction consists of 4 main methods, simple ureteroneocystostomy, Psoas-hitch with/without a Boari-flap, and ileal substitution. The technique is applied depending on how much of the ureter needs to be sacrificed and subsequently replaced. All three techniques will be presented. Case one underwent extravesical ureteroneocystostomy due to ureteral injury during a huge fibroid TLH (2640 g). The second case had ureteral extensive endometriosis. As we had to sacrifice 7cms of the ureter, we performed Boari-flap method with a Psoas-hitch. The third case was a recurrent corpus cancer case which required partial resection of the bladder and the pelvic ureter combined with the parametria and upper vagina. To compensate for the large defect, the interposition of the ileum, harvested with the vascular pedicle, was performed. In order to deal with extreme loss of the length of the ureter it is necessary for gynecologists to know how to perform tension free anastomosis.

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A Simple, Totally Laparoscopic Reconstructive Techniques for the Small Bowel and the Sigmoid Colon

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Two cases are presented in the video. The first case underwent functional end-to-end anastomosis after segmental resection of the ileum for intestinal endometriosis. For this technique, 2 linear staplers and 2 staples (45 mm and 60 mm) for each stapler. The second case underwent vaginal construction using a segment of the sigmoid colon for congenital vaginal atresia. After harvesting a segment of the sigmoid colon with a vascular pedicle, the segment is placed to create a new vagina. The transected sigmoid colon is then reconstructed using a circular stapler. For placement of the anvil we opened the oral stump of the sigmoid and placed and fixed the anvil totally laparoscopically. For these techniques only two 12 mm trocars and two 5 mm trocars are required. The stapling technique is much easier than a suturing technique and allows better blood perfusion to the anastomotic site. This approach enables safe, simple minimally invasive reconstruction.

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Applications of the Laparoscopic Morcellator Knife

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The laparoscopic morcellator knife was first described as a novel instrument in 2000 as an alternative to cautery and morcellator systems for uterine and myoma morcellation. The instrument is a reusable, inexpensive tool that can be vital to the armamentarium of the advanced gynecologic laparoscopist. We demonstrate its use in three clinical scenarios: supracervical hysterectomy amputation, colpotomy and morcellation of a large fibroid uterus.

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Single-Port Oophorectomy with AirSeal Trocar

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This video demonstrates a revolutionary new trocar system that does not use a mechanical flap vaalve. The valve system is an invisible air curtain created in the trocar hub that allows pneumoperitoneum to be maintained. Multiple instruments may be introduced simultaneously through the same trocar without losing gas pressure. We demonstrate an oophorectomy completed though a single 12 mm umbilical trocar. This trocar system will allow easy introduction of sponges and tissue extraction bags through the unique open channel trocar.

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Laparoscopic Cornuotomy Using Temporary Tourniqutte Suture in Interstitial Pregnancy

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Objective: To evaluate the efficiency of laparoscopic cornuotomy.
Design: Retrospective case review.
Setting: An urban medical center.
Patients: Eight patients with interstitial pregnancy who have undergone laparoscopic cornuotomy.
Interventions: Laparoscopic cornuotomy was performed using a temporary tourniquet suture and the injection of diluted vasopressin around the cornual mass. The tourniquet suture was removed completely after repairing the cornu.
Main outcome Measures : Operating time, hemorrhage, β-hCG.
Results: The estimated blood loss was 50 ± 22 ml (mean $\pm$ SD) and the operating time was 58 ± 16 min. The serum β-hCG level returned to within the normal range approximately 4 weeks postoperatively in all patients. There were no major postoperative complications, such as hemorrhage, and no postoperative adjuvant therapy was required.
Conclusion: Laparoscopic cornuotomy is a safe and effective method in interstitial pregnancy, and we believe that it has the advantage of preserving reproductive capacity over cornual resection.

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Laparoscopic Management of Interstitial Pregnancy and Subsequent Reproductive Outcome

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Interstitial pregnancy is a rare event comprising 1 % to 6 % of all ectopic pregnancies. Conservative laparoscopic management using cornuostomy is shown in this video. Diluted pitressin is injected around the interstitial pregnancy. Stay sutures are placed as a security measure. Retrospectively this did not seem to be necessary as there was not much bleeding from the site of the implantation in comparison to what traditionally has been reported during a cornual resection or hysterectomy. Using laparoscopic scissors a linear cornuostomy is made at the site of the most prominent bulge. All products of conception are then removed using endoscopic graspers and hydrodissection alternatively. There is no entry into the uterine cavity. The dissected area is then sutured with 0-vicryl in an interrupted fashion laparoscopically. This patient who had a history of preterm delivery conceived and delivered a viable neonate at 28 weeks without any complications.

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Preserving the Ovary as a Whole in Case with Huge Ovarian Cyst

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Ovary sparing surgery is an absolute requisite in a patient of child bearing age who wishes to preserve her fertility but had previously undergone contralateral oophorectomy. Therefore, we introduce a minimally invasive method of ovarian cystectomy via laparoscope-assisted mini-laparotomy by which an extremely huge ovarian cyst could be successfully removed without compromising normal ovarian tissue. Key Words: ovarian cyst, laparoscopic ovarian cystectomy, preserving the ovary.