this video is to teach early practitioners the etiology, pathophysiology, management and surgical technique behind laparoscopic repair of vesico-vaginal fistulas.

27 Video Session 2 - Urogynecology
(11:21 AM - 11:26 AM)

Transperineal Overlapping Sphincteroplasty for Repair of Rectovaginal Fistula with Anal Sphincter Defect

Williams KS,1 Shalom DF,1 Winkler HA,1 Caliendo FA,2 1Division of Female Pelvic Medicine and Reconstructive Surgery, North Shore-Long Island Jewish Health System, Great Neck, New York; 2Division of Colorectal Surgery, North Shore-Long Island Jewish Health System, Great Neck, New York

Objective: To review the clinical presentation and surgical approach to a patient with rectovaginal fistula (RVF), fecal incontinence and anal sphincter defect. Patients with RVF commonly present with passage of stool per vagina or a foul-smelling discharge. If RVF patients report fecal incontinence, evaluation of the anal sphincter is indicated. Workup includes: endoanal ultrasound, anorectal manometry and pudendal nerve terminal motor latency (PNTML) testing. Endoanal ultrasound can localize anal sphincter defects. Anal manometry measures functional impairment and PNTML testing can detect an underlying neuropathy. The transvaginal, transanal or transperineal approach are options for the localized repair of RVF. This video outlines the key surgical steps for transperineal overlapping sphincteroplasty. We recommend this approach for patients with complex, distal RVF, anal sphincter defect and fecal incontinence.

Conclusion: Transperineal overlapping sphincteroplasty allows for the simultaneous repair of a sphincter defect in patients presenting with a RVF and fecal incontinence.

28 Video Session 2 - Urogynecology
(11:27 AM - 11:33 AM)

A Teaching Guide for Retropubic Mid-Urethral Sling
Mangel J, Pollard R. Obstetrics & Gynecology, MetroHealth Medical Center, Cleveland, Ohio

This video entitled “A Teaching Guide for Retropubic Mid-Urethral Sling” serves as a simplified, reproducible technique that can be utilized to teach surgeons in training as well as experienced surgeons who are learning this procedure. The video outlines each step necessary for successful placement of a retropubic mid-urethral sling.

29 Video Session 2 - Urogynecology
(11:34 AM - 11:40 AM)

Anatomical Principles for Laparoscopic Sacropinous Ligament Transection in Pudendal Neuralgia
Carrillo JF, Benjamin AR, Howard FM. Obstetrics and Gynecology, University of Rochester School of Medicine and Dentistry, Rochester, New York

Pudendal neuralgia is a neuropathic condition. Entrapment is a common cause, often encountered at the small space between the sacropinous and the sacrotuberous ligament. When entrapment is diagnosed, 4 different approaches to decompression have been described. In this video we will present the laparoscopic approach. We will review the neurovascular anatomy of the pelvic side wall, related to the sacropinous ligament and the pudendal nerve; and the technique to expose these structures in order to transect the sacropinous ligament. Knowledge of the neurovascular structures at the pelvic side wall is essential to safely perform this procedure. This technique can be used as a minimally invasive approach in patients with pudendal nerve entrapment at the sacropinous and sacrotuberous ligament, with adequate improvement of symptoms and faster recovery than other techniques.

30 Video Session 2 - Urogynecology
(11:41 AM - 11:47 AM)

Vaginal Hysterectomy, Modified Mayo Mcalls Suspension with the Assistance of the Magrina Vaginal Bookwalter (R): A Unique Surgeon’s Perspective Using a Telescopic Lens
Agrawal A, Deveneau NE, Francis SL. Female Pelvic Medicine and Reconstructive Surgery, University of Louisville, Louisville, Kentucky

The vaginal approach to hysterectomy offers lower incidences of urologic complications, shorter post-operative recovery periods, and decreased amounts of blood loss compared to abdominal approaches. Unfortunately many residents are losing their confidence in vaginal surgery. Vaginal surgery requires increased dexterity and prolonged retraction by the surgical team. The Magrina Vaginal Bookwalter® provides adequate exposure and helps decrease surgeon fatigue. In an increasing litigious environment the modified mayo mcall suspension uses the patient’s own tissue to correct their pelvic floor defects. This educational video will demonstrate how to perform a vaginal hysterectomy with a modified mayo mcall suspension. This technique will show how the Magrina Bookwalter® can be easily setup and utilized during the surgery. A high definition telescopic lens enables us to display complex deep anatomical structures which are often difficult to visualize during surgery. Throughout the video, surgical techniques will be emphasized to avoid potential complications.

31 Video Session 2 - Urogynecology
(11:48 AM - 11:54 AM)

Chronic Pelvic Pain from Mesh Anchors Used in Pelvic Floor Repairs
Mosbrucker CM. Franciscan Womens Health, Urogynecology and Pelvic Surgery, Gig Harbor, Washington

This video describes the technique and relevant anatomic landmarks for removing mesh anchors placed during a pelvic floor mesh kit (Elevate). A case is presented, as well as a study describing the locations of the nerves in the vicinity of the sacropinous ligament.

32 Video Session 2 - Urogynecology
(11:55 AM - 11:57 AM)

Moving Fibroid
Balica AC, Egan S, Keselowsky K, Scaramella NM, Bachmann GA. Obstetrics, Gynecology and Reproductive Sciences, Rutgers Robert Wood Johnson Medical School, New Brunswick, New Jersey

Imaging techniques have advanced significantly in the past decade, and real time aspects of pelvic pathology, such as liquefaction of degenerating fibroids, will more commonly be captured, as this video demonstrates. This segment was taken during the pelvic ultrasound of a 69 year-old, healthy female, being evaluated for pelvic discomfort. During the transvaginal imaging, the 17mm by 16mm by 18mm intramural fibroid was noted to have a swirling motion within. This activity was captured on a GE VolusonE8 using a 5-9MHz transvaginal probe. Two 10 second cine-loop playback clips were used to record the motion. These images support the diagnosis of a degenerating fibroid as the possible etiology of the patient’s symptoms, a diagnosis made feasible by this imaging.

33 Video Session 2 - Urogynecology
(11:58 AM - 12:04 PM)

Tips and Tricks on How to Avoid Injury during Laparoscopic Sacrocolpop/Hysterectomy
Titz H. Evin Women’s Health, Brisbane, Qld, Australia

Laparoscopic sacrocolpop/hysterectomy with mesh provides anatomic pelvic restoration, durable results, and less dyspareunia with 78-100% success rate.
Unfortunately it has risks of injury to bladder, ureter, rectum, small bowel and L5-S1 disc. Vascular injury during dissection of promontory can cause life-threatening bleeding. Small bowel injury can be missed 25 to 50 % of time and has 20 % mortality rate when it is not diagnosed intraoperatively. This video demonstrates: 1. Anatomic relation between mid sacral promontory, left iliac vein, right common iliac artery, right ureter, L5-S1 disc. 2. Challenging cases of right aberrant branch from left iliac vein and very limited vessel-free window in sacral promontory due to anatomic variation of right common iliac artery and left common iliac vein. 3. Tips and tricks on how to safely dissect promontory and avoid injury to right ureter, bladder, rectum, small bowel, L5-S1 disc.

34 Plenary 2 - Oncology
(12:05 PM - 12:14 PM)

Incidence and Outcome of Uterine Sarcomas Diagnosed in a Continuous Cohort of Patients Referred for Treatment of Uterine Fibroids by Minimally Invasive Procedures
Fazel A, Thoury A, Brouland JP, Corneliis F, Le Dref O, Benifuji J
1Obstetrics and Gynecology, Hopital Lariboisiere-APHP, Paris, France;
2Interventional Radiology, Hopital Lariboisiere-APHP, Paris, France;
3Pathology, Hopital Lariboisiere-APHP, Paris, France

Study Objective: To assess the incidence and outcome of uterine sarcomas diagnosed among a continuous cohort of 2824 patients referred for fibroid treatment in an academic setting with minimally invasive procedures.

Design: Prospective study (Canadian Task Force classification II-3).

Setting: University Hospital, Tertiary Center.


Intervention: All patients had a clinical examination, endometrial sampling, pelvic ultrasound, MRI reviewed by two different radiologists, one being a senior advisor in oncologic radiology. Patients were treated either by Uterine Artery Embolization (UAE), first described in 2002 (CESAM), vaginal procedure or by laparotomy.

Measurements and Main Results:

<table>
<thead>
<tr>
<th>Measurements</th>
<th>Robotics BMI 40-49.9: n=40</th>
<th>Robotics BMI 50-59.9: n=15</th>
<th>Robotics BMI 60+: n=3</th>
<th>Laparotomy BMI 40-49.9: n=19</th>
<th>Laparotomy BMI 50-59.9: n=3</th>
<th>Laparotomy BMI 60+: n=2</th>
</tr>
</thead>
<tbody>
<tr>
<td># of patients with pelvic LNs removed</td>
<td>96.6 (38) 1</td>
<td>100 (15)</td>
<td>66.6 (2)</td>
<td>100 (19)</td>
<td>66.6 (2)</td>
<td>100 (2)</td>
</tr>
<tr>
<td># of patients with para-aortic LNs removed</td>
<td>75 (30)</td>
<td>73.3 (11)</td>
<td>66.6 (2)</td>
<td>78.9 (15)</td>
<td>33.3 (1)</td>
<td>0 (0)</td>
</tr>
<tr>
<td>Median room time (min)</td>
<td>252</td>
<td>280</td>
<td>300</td>
<td>165</td>
<td>183</td>
<td>222</td>
</tr>
<tr>
<td>Median case time (min)</td>
<td>197</td>
<td>203</td>
<td>248</td>
<td>125.5</td>
<td>120</td>
<td>115</td>
</tr>
<tr>
<td>Median positioning/intubation time (min)</td>
<td>34.5</td>
<td>42</td>
<td>37</td>
<td>33</td>
<td>39</td>
<td>82.5</td>
</tr>
</tbody>
</table>

1. % (n) of patients.

Conclusion: It appears that after a certain level of BMI there is a higher level of difficulty with performing para-aortic lymph nodes however that difficulty can be minimized with robotically assisted surgery. It appears that in centers that are specialized in robotics and performing surgery on obese patients, good results can be achieved with minimal conversion rates.

35 Plenary 2 - Oncology
(12:15 PM - 12:24 PM)

What Level of Obesity Affects Results of Surgery: A Cohort Study of Robotics and Laparotomy for Staging of Endometrioid Endometrial Cancer among Patients with Basal Metabolic Index (BMI) of 40 and Above2
Kincy T, Fornalik H, Callahan M 1St. Vincent Women’s Hospital OB/GYN Residency, Indianapolis, Indiana; 2St. Vincent Gynecologic Oncology, Indianapolis, Indiana

Study Objective: To determine what level of obesity affects results and complications of surgical staging for endometrioid endometrial cancer between robotics and laparotomy in patients with a BMI of 40 and above.

Design: Retrospective cohort study of patients who underwent surgery. Results were analyzed according to level of obesity separated into groups of 40-49.9, 50-59.9 and 60 and up, as well as mode of surgery.

Setting: Community Hospital tertiary care center.

Patients: Women undergoing surgical staging for endometrial cancer with two gynecologic oncologists with a BMI of 40 and above were enrolled and post operative outcomes were recorded over a span of 90 days.

Measurements and Main Results: The total room time and total case time were statistically significantly shorter between laparotomy and robotics (p<.001); however there was no difference in positioning/intubation time between the two surgeries. There was no difference between laparotomy and robotics and number of lymph nodes removed with respect to pelvic and para-aortic lymph node dissection (LND) and BMI. If LND was performed, robotic patients with BMI 50-59.9 and 60+ were more likely to undergo para-aortic LND compared with laparotomy patients. (73.3% and 66.6% vs. 33.3% and 0%). There was a statistically significant difference between estimated blood loss (150 mL in the robotics group vs. 600 mL in the laparotomy group, p<.0001), but no difference in the transfusion rate. There was no difference in major complications in BMI 50 and above in either group. There were no conversions to laparotomy in the robotics group.

Extraperitoneal Endoscopic Total Retropereitoneal Lymphadenectomy-No Bowel Surgery
Andou M, Nakajima S, Yanai S, Kurotsuchi S. Gynecology, Karashiki Medical Center, Karashiki-shi, Okayama-ken, Japan

We will present an ultra-minimally invasive retroperitoneal lymphadenectomy using the extraperitoneal approach. This technique has been developed to make oncologic surgery less invasive and a more patient friendly procedure.

Design: A description of our surgical technique

Setting: Community hospital

Patients: Women who underwent endoscopic extraperitoneal paraaortic and pelvic lymphadenectomy for endometrial cancer.