A 22-year-old morbidly obese young woman presented with acute abdominal pain, obstipation, nausea / vomiting and unintended weight loss. Emergent evaluation revealed elevated serum creatinine and a CT scan showing a pelvic mass and hydronephrosis. MRI demonstrated a 17 cm kidney-shaped posterior uterine mass, presumed to be a fibroid. Laparoscopy confirmed incarceration of the myoma at the level of the sacrum, causing partial ureteral and distal bowel obstruction. A difficult but uncomplicated myomectomy was performed using a combination of conventional and robotic laparoscopy. The patient recovered well with dramatic symptom improvement and resolution of hydrourerter.

Laparoscopic Treatment of Intestinal Obstruction in a 22+ Weeks Pregnant Woman
Titiz H. Evin Women's Healthcare, Brisbane, QLD, Australia

Intestinal obstruction in pregnancy is rare (1 in 3000). There is high maternal (6%) and foetal mortality (26%) rate due to delayed diagnosis and treatment. A 35 years old 22+ weeks pregnant woman, G2P1 with a history of Caesarean section and appendectomy presents with, on and off, 3 days history of generalised abdominal pain, bloating and nausea. After her initial conservative management failed and her symptoms became more severe, she was taken to operating room for laparoscopy and +/- laparotomy. After the pre-operative preparation, laparoscopy revealed single band adhesion, which was divided. Otherwise there was not any other significant pathology on laparoscopy. After the operation, she has rapidly recovered and rest of her pregnancy and delivery was uneventful. This video demonstrates literature review, pre-operative preparation, entry technique, port placement, and laparoscopic division of single band adhesions, examination of both adnexa and bowel in a 22+ weeks pregnant woman.

Laparoscopic Hysterotomy for Removal and Repair of Caesarean Scar Early Ectopic Pregnancy
Titiz H. Obstetrics & Gynecology, Evin Women’s Healthcare, Brisbane, QLD, Australia

A Caesarean scar ectopic pregnancy is a rare and delay in diagnosis and treatment can cause serious morbidity (e.g. severe bleeding, hysterectomy etc.) and mortality. Therefore early treatment is important. But at the early stage, laparoscopic or hysteroscopic treatment can be challenging as the laparoscopy and hysteroscopy can be normal due to lack of bulging mass towards the uterine or abdominal cavity. This is a case of 30 years old woman, G2P1 with the history of previous Caesarean section, presenting at 6+ weeks GA with no symptom and ultrasound consistent with c-section ectopic pregnancy. After extensive counseling, she underwent laparoscopic hysterotomy and removal and repair of c-section scar ectopic pregnancy. This video demonstrates the hysterectomy and the laparoscopic technique of: use of Foley catheter with metal introducer as “bladder probe,” vaginal retractor to delineate anterior vaginal fornix, hysterotomy, removal of ectopic pregnancy and repair of caesarean scar.

Minimally Invasive Approach to a Large Pelvic Mass

A 22-year old G0 noted gradual increased abdominal girth for eight years. A CT abdomen and pelvis showed a 33cm cystic mass filling her abdomen and pelvis. No solid components or hydraphadenopathy were seen. Normal tumor markers. The case was started with a 5mm incision at the umbilicus, and a diagnostic laparoscopy was done. A small 3cm transverse incision was made at 2 finger-breaths above the pubic symphysis with a vertical fascial incision. The medium Alexis retractor was used for visualization. The gallbladder trocar was used to penetrate the cyst and suction all its content. Nine liters of serous fluid was removed. A traditional cystectomy was completed. The cyst was arising from the left mesosalpinx. The tube was dilated and abnormal; a salpingectomy was done. Final pathology was benign paratubal cyst. The patient went home the same day and did well.

VIDEO POSTER: LAHV; LSH; TLH; VH (HYSTERECTOMIES)

LAVH for Women with Anterior Wall Adherence after Cesarean Section
Bae JW, Ko KH, Choi JS, Kim KT, Bae J, Lee WM, Lee JH, Park SY, Kim JY. Obstetrics and Gynecology, Dong-A University School of Medicine, Busan, Republic of Korea; Obstetrics and Gynecology, Hanyang University College of Medicine, Seoul, Republic of Korea; Obstetrics and Gynecology, Sanggyunkwan University School of Medicine, Seoul, Republic of Korea

A 40-year-old Korean woman, who underwent two times of Cesarean section, has been suffered from dysmenorrhea for nine years. I performed LAHV with both salpingectomy after adhesiolyis of anterior wall adherence because her conservative treatments including oral pills, pain killers, and LND-IUS were failed. I inserted three trocars in her upper abdomen to make a pneumoperitoneum and to assess the dense adhesion efficiently. Firstly, I performed adhesiolyis between anterior abdominal wall and the uterus using a dissecting Metzemberm with monopolar coagulation. I moved the 5-mm telescope from the right upper lateral port to the umbilical port. I inserted the last ancillary port on the upper portion of symphysis pubis. LAHV was successfully done. The final histopathological report showed adenomyosis, leiomyoma, and paratubal cyst.

Laparoscopic Supracervical Hysterectomy in a Patient with Cadaveric Renal Transplant
Eisenstein DJ. Division of Minimally Invasive Gynecology, Henry Ford Health Systems, West Bloomfield, Michigan

This video case study demonstrates laparoscopic approach to hysterectomy in a patient with cadaveric renal transplant. Surgical strategies including access, trocar placement, energy source, and cystoscopy are described. The anatomic relationships between the renal pelvis and ureter to the right pelvic sidewall structures are demonstrated, and dissection techniques to isolate and protect the transplant tissue from injury are emphasized. The presence of renal transplant in the pelvis is not a contraindication to laparoscopic hysterectomy.