**Uterine Hemisection in Laparoscopic Hysterectomy**

**Leyva L, Castellanos G, Herrera O. Minimally Invasive Surgery, National Institute of Perinatology Mexico, Mexico City, Federal District, Mexico**

We present a video to demonstrate the extraction of a large uterus in a laparoscopic hysterectomy by making hemisection of the uterus corpus.

**Three Methods of Vaginal Cuff Closure**

**Manoucheri E, Greenberg J, Brigham & Women’s Hospital, Boston, Massachusetts; Bingham & Women’s Faulkner Hospital, Boston, Massachusetts**

Our video presents three methods of vaginal cuff closure utilizing bidirectional barbed suture and unidirectional barbed suture. The first method shows a bidirectional barbed suture with two needles snagged on to the ends. The initial step starts at the midline and sutures towards each apex of the vaginal cuff. The second method is using the first needle of the bidirectional barbed suture to close the vaginal cuff in a continuous fashion and the second needle to reperitonealize the vaginal cuff. Our final method shows the V-Loc unidirectional suture used at both ends and suturing towards the midline. These three methods showcase the various ways a vaginal cuff can be closed as well as highlights the advantages of the barbed suture, both bidirectional and unidirectional.

**Robotic Assisted Total Laparoscopic Hysterectomy: The Importance of Ureterolysis**

**Nawfal AK, Eisenstein D. Obstetrics and Gynecology, Clemenceau Medical Center-Affiliated with Johns Hopkins International, Beirut, Lebanon; Obstetrics, Gynecology and Women’s Health Department, Henry Ford Hospital, Detroit, Michigan**

The importance of performing pelvic side wall dissection and ureterolysis is emphasized in this video presentation. We present a 42 y.o lady known to have Neurofibromatosis and was evaluated in the Women’s Health clinic for metrorrhagia and pelvic pain. She was counseled for and consented to undergo a Robotic assisted Total laparoscopic hysterectomy. During the procedure distortion of the pelvic anatomy was noted with uterine and ovarian adherences to the pelvic sidewalls bilaterally. Prior to coaptation and cutting of the left infundibulopelvic ligament the left ureter was identified, however on further dissection and ureterolysis bilateral ureteral duplication was identified and we demonstrate how failure to perform this would have lead to ureteral injury.

**Laparoscopic Hysterectomies in Large Uterus: Myth and Realities**

**Rivero JA, Bosque VA, Angulo AC, Araujo MD, Esposito CT. Ginecologia, Centro Medico Docente La Trinidad, La Trinidad, Caracas, Venezuela**

The hysterectomy is the most common surgery in the united states and the minimally invasive approach is becoming the standard of care. Many authors consider that the laparoscopic hysterectomies should be offer to all patients including those mention above. Some suggest that the size is not a significant factor for the conversion of the laparoscopic hysterectomy being more important the uterus width, the mobility and the presence of lateral myomas that could prevent access of the uterine vessels.

Some available alternatives to carry out a hysterectomy in very large uterus are: the uterine ligature in its origin in the internal iliac vessel is useful in many cases, to perform a myomectomy before starting the hysterectomy is also another very helpful, and finally in situ morcelation of the uterus could enable the surgeon to accomplish without complications a laparoscopic hysterectomy.
● Ureteral injury is a rare but important complication of gynecologic surgery with serious morbidity. Gynecologic surgery accounts for 75% of iatrogenic ureteral injuries. Incidence of ureteral injury 1-8% during abdominal and pelvic surgery. Nearly half of them diagnosed after the operation. Use of prophylactic ureteric stent may reduce the risk of ureteric injury. It has been controversial. Literature was reviewed. Evidence and opinion against and for the use of prophylactic ureteric stents were presented.
● Aim of this video is to demonstrate how infrared ureteric catheter can prevent ureteric injury at all levels (pelvic brim, ovarian and uterine vessels, pelvic side wall, vaginal cuff) in this case of total laparoscopic hysterectomy and bilateral salpingooophorectomy in a frozen pelvis with bilateral endometrioma.

VIDEO POSTER: NEW INSTRUMENTATION

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The Path to Pure NOTES
Andou M, Kanau H, Kurotsuchi S, Takano M. Gynecology, Kurashiki Medical Center, Kurashiki-shi, Okayama-ken, Japan

Background: We present our step by step journey to pure NOTES via transvaginal laparoscopy.

Methods: We will show four minimally invasive approaches in ovarian cystectomy, myomectomy and adnexectomy cases. We used a transvaginal flexible fiberscope in all cases. In Case 1, 2 we used 5mm and 3mm abdominal ports for manipulation. In Case 3, we used one abdominal port and 2 vaginal ports which allowed for one manipulation port in the vagina and one in the umbilicus. Case 4 required no abdominal ports, only a transvaginal access platform in the vagina equipped with 4 trocars- one camera, two forceps and one uterine manipulator.

Results: All procedures were completed without conversion to open laparotomy or standard laparoscopic approach. The cosmetic result was excellent.

Conclusion: With the right skills and equipment it is technically feasible to perform port reducing surgery in selected cases. We have succeeded in performing pure NOTES for adnexectomy.

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Minilaparoscopy: Best of Both Worlds
Cholkeri-Singh A, Miller CE. Ob/Gyn, Advocate Lutheran General Hospital, Park Ridge, Illinois

Conventional laparoscopy itself has several clinical advantages over laparotomy. These include reduced blood loss, hospital length of stay, narcotic use, adhesion formation and recovery. Laparoscopy is well accepted amongst physicians and patients. However, as the awareness of laparoscopy has increased amongst our communities, so has the concern of cosmesis with abdominal wound scarring. When comparing conventional laparoscopy to minilaparoscopy, minilaparoscopy has not only shown improved cosmesis, but also that it is safe and feasible with reduced postoperative pain and risk of port-site complications, including herniation, infection and bleeding. Minilaparoscopy has comparable operative times, hospital stay and morbidity. This instrumentation can hybrid with single-port, robotic or conventional laparoscopy to reduce port size and/or ease surgical technique.

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Comparison of Laparoscopic and Robotic Application of Seprafilm in Post-Operative Deep Endometriosis and Pelvic LN Dissection
Chuang Y-C, Lu HF, Peng FS, Ting WHS. OBS & Gyn, Far Eastern Memorial Hospital, New Taipei City, Taipei, Taiwan

Anti-adhesion barrier seprafilm has been proved to effective both in benign and malignant gynecologic diseases. Minimal invasive approach of deep infiltrative endometriis and endometrial cancer with pelvic LN dissection has been a global trend. We try to compare the application procedure of seprafilm in both technique. The basic procedure of cutting commercial available seprafilm sheet into 6-9 pieces and roll in an aseptic plastic sheet into a roll and inserting through 10 mm trocar into the abdominal cavity was the same. The difference is to unroll the seprafilm roll and apply it in the traumatized rough surface with conventional forceps or Robotic arm forceps. In this video we will show the 6 video clips consecutively in the sequence of 1. basic procedure, 2. conventional laparoscopy in deep endometriosis. 3. Robotic procedure 4. Robotic application in deep endometriosis. 5. conventional laparoscopy in pelvic LN dissection. 6. Robot in LN dissection.

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Chair Laparoscopy: Sitting Surgeon Performing Laparoscopy
Jain N. Obs & Gynae, Vardhman Trauma & Laparoscopy Centre Pvt. Ltd, Muzaffarnagar, UP, India

Study Objective: To assess the safety and feasibility of performing laparoscopy in the sitting position to decrease surgeon fatigue.

Design: All major and minor procedures performed as ‘Chair Laparoscopy’ over past two years.

Setting: Tertiary referral for advanced laparoscopy surgery.

Patients: 125 cases ranging from 15-70 yrs of age for varying indications.

Intervention: Chair laparoscopy performed successfully.

Measurement and Main Result: Lap surgeons are facing extensive, exhaustive procedures which inspire of surgical skill become lengthy and tiresome. As a result the patient recovers faster but the surgeon is left fatigued. To decrease surgeon fatigue we devised CHAIR LAPAROSCOPY, which is performed on a special chair with foot bar. Certain modifications which support chair laparoscopy have been made and surgeon fatigue considerably decreased.

Conclusion: All major & minor cases successfully completed as chair laparoscopy, including suturing, adhesiolysis & morcellation.

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Minitouch Endometrial Ablation: An Anaesthesia Free Procedure in an Office Environment
Penketh RJ, Bruen E, Patwardhan A, Hill S, Groves L, Griffiths AN. Department of Gynaecology, University Hospital of Wales, Cardiff, United Kingdom

This novel micro endometrial ablation technique functions by delivery of microwave energy to the endometrium via an intra-cavity induction loop. The device diameter 3.5mm is such that cervical dilatation is not required. In addition the procedure is of rapid duration (60 seconds) for the majority of endometrial cavities. Women with larger cavities require two applications of 60 and 30 seconds.

This video demonstrates the procedure for a woman who has been given pre-emptive analgesia with diclofenac and paracetamol but has not had local anaesthetic injected into her cervix which did not require dilatation. She experience pain 4/10 during the 60 seconds but this subsided immediately on completion and she was able to go home 30 minutes later. This new device represents a third generation endometrial ablation technology not only in terms of miniaturisation but also ease of use and patient acceptability. This represents a step change in comparison with currently available technology but clearly final validation of this device will require longer term follow up than the short term data currently available.

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2 Port Robotic Hysterectomy Utilizing the FormiSee Lighted Manipulator/Colpotomizer
Salvay HB. Ob/Gyn, Palo Alto Medical Foundation, Santa Cruz, California

Reduced Port Robotics uses the GelPoint Access System in which three ports are placed in a single umbilical incision. The demonstration of the FormiSee System allows a lighted target for colpotomy and bladder dissection. The reduced haptics on the da Vinci SI system is improved by a LED light on the end of the vaginal delineator.