Laparoscopic Uterosacral Ligament Colposuspension
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Prior to every hysterectomy, both vaginal support and urinary continence should be assessed and addressed by the surgery. In this patient with uterine carcinoma and symptomatic uterovaginal prolapse, surgery to address both the cancer and the anterior wall defect and traction cystocele are undertaken laparoscopically. All the steps of the procedure are demonstrated, as are the steps taken to assure the safety of the colposuspension.

Laparoscopic Entry can fail in morbidly obese patients. Failure rate varies from 4% to 29%, depending on which entry technique is used. Umbilical stalk is a fibrous remnant of umbilical vessels and runs from the linea alba to the demis of the umbilicus. Peritoneum is fused to the junction between umbilical stalk and linea alba (single layer of fascia). This junction is the thinnest entry point into the abdominal cavity even in extremely obese patients. Hasan entry is the combination of an incision to the junction of umbilical stalk and linea alba with umbilical stalk elevation technique and direct optic entry through fascia incision and peritoneum. The video shows the followings: 1. Demonstration of umbilical anatomy and open entry surgical technique with elevation of umbilical stalk in a patient with normal BMI. 2. Demonstration of Hasan entry technique in a patient with BMI of 49.

Laparoscopic Management of Ovarian Torsion in a 1st Trimester Pregnant Patient
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Adnexal torsion is a gynecologic emergency. This video demonstrates a minimally invasive operative approach for treatment of ovarian torsion during a 1st trimester pregnancy. A 37-year old G2 P1 female patient at 6 weeks gestation with history of polycystic ovarian syndrome and previous in vitro fertilization twin pregnancy presented to the emergency department with sudden onset left lower quadrant pain. A transvaginal ultrasound showed a 6-week intrauterine gestation and asymmetric enlargement of her left ovary. Despite normal vascular waveform, these findings in the setting of acute left sided pain suggested the possibility of ovarian torsion. Upon performing laparoscopy an enlarged torsed left ovary was confirmed. Detorsion of the left ovary and shortening of the uteroovarian ligament was possible. But laparoscopic removal of extremely large ovarian cyst can be performed. This video aims to describe proper patient selection for primary port placement in the left upper quadrant. We will also review techniques for entry in this space including relevant anatomy of the anterior abdominal wall. Finally, we will demonstrate both anatomy and technique via surgical video of optical entry at Palmer’s point. This video will be of benefit to learners who seek to expand their toolkit to increase the safety of minimally invasive surgery in more complex surgical cases.

Laparoscopic Oophorectomy and Intracorporeal Salpingectomy for Extremely Large (30 cm) Ovarian Cyst
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Laparoscopy should be used in the management of ovarian cyst whenever it is possible. But laparoscopic removal of extremely large ovarian cyst can have following challenges: 1. Inadvertent puncture of cyst, 2. Reduced visualisation, 3. Difficulty in removal, 4. Potential risk of malignant ovarian neoplasm. Possibilities of borderline and malignant ovarian tumor for extremely large ovarian cyst(10-35cm) are low (3.8 and 2.5 % respectively). Case: 56 years old woman was admitted with severe abdominal pain. Ultrasound and CT showed right ovarian mucinous cyst with septations (30x23x15 cm) starting from pelvis and extending to epigastrium with no sign of malignancy. Tumor markers and blood tests were negative. After counseling and consenting, patient had laparoscopic right extracorporeal oophorectomy and intracorporeal salpingectomy. Post-operative care was uneventful. Histopathology showed borderline mucinous ovarian tumor. This video demonstrates the surgical technique of extracorporeal oophorectomy and intracorporeal salpingectomy for an extremely large ovarian cyst.