Laparoscopic Uterosacral Ligament Colposuspension

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.

Loss of Port Placement Triangulation

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 ultrasound showing 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 uterovarian ligament was performed to minimize future ovarian mobility. She had a follow up ultrasound 1 week after the procedure, which showed a live pregnancy with a slightly enlarged left ovary and normal internal Doppler flow.

Laparoscopic Management of Ovarian Torsion in a 1st Trimester Pregnant Patient

The case presented is of a 38 y/o female with an enlarged uterus and a 10 cm fibroid noted on imaging studies. The patient underwent a total laparoscopic hysterectomy, bilateral salpingectomy, and apical suspension from a mid-line umbilical approach. Intra-operative weight of the uterine specimen was 566 grams.

The following presentation demonstrates several useful techniques to overcome the loss of port placement triangulation, when performing a laparoscopic hysterectomy from a mid-line umbilical approach. When the vaginal approach is less feasible, these techniques allow the surgeon to offer patients similar cosmetic benefits, while operating in the vertical plane.

Tips and Tricks: Bagging the Big Ones

In this video we present a stepwise approach to placing a 20 week uterus (975g) inside a bag for morcellation via mini-laparotomy. Tips and tricks are reviewed to ensure 1) efficient transfer of the specimen inside the bag and 2) maximal exposure during morcellation via mini-laparotomy.

Laparoscopic Entry in the Left Upper Quadrant

Prior abdominal surgery is associated with a high rate of intra-abdominal adhesions, ranging anywhere from 25 to greater than 50%. Adhesions can obscure visualization and increase risk of visceral injury when present at the site of primary trocar placement. In fact, up to half of injuries during laparoscopic surgery occur during entry, in large part due to adhesive disease. The left upper quadrant is generally spared from significant adhesive disease. 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.

Cosmetic Hysterectomy: Strategies to Overcome the Loss of Port Placement Triangulation

Clinical circumstances arise which prevents a surgeon from offering a hysterectomy from the vaginal approach. Any effort made to limit incisions to the umbilicus and minimize scarizing has cosmetic benefits. A mid-line umbilical approach however, creates many challenges due to the loss of instrument triangulation.