To achieve this type of running, baseball-style suture, we routinely use the StrataFix Knotless Tissue Control Device. This suture closes the hysterotomy securely, and the baseball-style buries the suture bars so that they do not attach to the bowel or omentum. We believe that our technique can be easily learned and utilized by surgeons, and that by doing so they can continue to offer safe, and efficient methods of closing the hysterotomy during laparoscopic myectomy.

Subcutaneous emphysema is a relatively common sequela of laparoscopic surgery that is often underreported in the literature. With advances in MISG surgery, it is important to identify changes in surgical techniques that may increase the incidence of subcutaneous emphysema to minimize postoperative morbidity. This video reviews a case report of subcutaneous emphysema recognized on post-operative day seven after robotic-assisted modified radical hysterectomy for recurrent Stage IIIC Fallopian tube carcinoma. The objective of this video is to indicate the incidence of subcutaneous emphysema, pathophysiology of CO₂ insufflation, and the risk factors and clinical findings associated with subcutaneous emphysema. It is important to recognize these risk factors and possible causes in association with laparoscopic or robotic surgery and prompt compensatory mechanisms are necessary to avoid clinical sequelae.

There is no clear guideline about surgical technique of total laparoscopic hysterectomy for extremely large uterus. An extremely large uterus can obstruct the pelvis and it can be difficult to access the pelvic space around the utero-vaginal junction. Therefore, using a uterine manipulator that can manipulate extremely large uterus and expose utero-vaginal junction is important.

Case: A 44 years old, G0P0, patient with the history of extremely large uterus (34 weeks’ size) decided to have definitive surgical treatment after 5 years’ follow-up. All pre-operative investigations did not suggest any malignancy. Patient had a total laparoscopic hysterectomy and knife morcellation through mini hysterotomy after discussing the treatment options and possibility of sarcoma. Uterus weight was 2320 grams. Histopathology showed benign fibroids. Patient did not have any postoperative complications. This video demonstrates the surgical technique, tips and tricks on how to do total laparoscopic hysterectomy for an extremely large uterus.

This video demonstrates a novel specimen retrieval and containment system and the step by step instructions for its use. The containment bag provides a larger opening with a self opening flexible nitinol wire for easier placement of the specimen into the bag. The nitinol wire has a blue marker for orientation. The smaller nitinol wire allows for the placement of the bag through a trocar or smaller incision. The bag is made of a clear sturdy 600 pli polyurethane that withstands 11,000 psi and resists tearing. The two versions of the bag have a volume capacity of 2100 ml and 5500 ml. Once externalized, a separate flexible ring can be placed in channels in the opening of the bag to create a self retaining retractor that provides exposure, as well as helps hold the specimen up to the incision for easier and safer removal.

The purpose of the video is to demonstrate an innovative technique of laparoscopic knot in extremely narrow space. Our case was a 28-year-old female at 31 gestational week who was presented with progressing right lower abdominal pain and was suspected of right adnexal torsion and infarction. We performed laparoscopic adnexectomy successfully and the patient got discharged without any complication. No related adverse maternal or fetal outcome occurred in her later delivery. The challenge of this case was an enlarged uterus of 31 gestational week which left us little operative space to ensure ligation. Therefore, we made a little improvement build on the traditional knot guide, and named it as "self-trap" technique.

To make colpotomy during total laparoscopic hysterectomy safer, easier and more patient as well as surgeon friendly, a bipolar colpotomizer was used along with Marwah’s uterine manipulator.