A 33 year-old, gravida 2 and parity 2 women presenting with abdominal pain located on right iliac fossa following to history of intermittent pelvic pain for nine months after her tubal ligation performed at second cesarean section was admitted to outpatient clinic. It is always hard to have a preoperative diagnosis in the case of isolated fallopian tube torsion. The torsion must be suspected even when it is not presented with an acute clinic and also even suspicion of torsion merits diagnostic laparoscopy especially when it presents together with risk factors. The mechanism beneath the predisposing effect of tubal ligation might be derived from its destructive effect on bloody supply, venous and lymphatic drainage of the mesosalpinx which leads to formation of hydrosalpinx and diminished anatomical support. Those factors together cause the tubal remnants twist around their own bodies especially on the right side lacking protective effect of Sigmoid colon.

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Bleeding Control Techniques in Laparoscopic Surgeries
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The application of immediate pressure and suturing is difficult during strong bleeding in laparoscopic operations compared with open surgeries. Although a conversion to laparotomy can be necessary, hemostasis during laparoscopy may reduce the burden on the patient. We think that the most important steps for hemostasis during laparoscopic operations is temporary hemostasis. In addition, it is important to keep the field of vision clear and make the anatomical position clear. After this initial step, it is possible to plan a strategy such as using gauze pressure, suturing, vessel clips, or other techniques. As a result of using these techniques, in our 5960 laparoscopic surgeries over 5 years (2011-2016), there were only 3 cases that required a conversion to laparotomy due to severe bleeding, and only 2 cases needed a blood transfusion.

In this video, we will show hemostatic strategies in various situations in laparoscopic surgeries.

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Laparoscopic Evaluation and Excision of Retropertitoneal Parasitic Myoma
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The aim of this video is to showcase the extraction of a retropertitoneal parasitic myoma following abdominal myomectomy and hysterectomy without prior use of morcellation. Parasitic myomas are a condition that is thought to result from the seeding of fibroid fragments into the peritoneum, most commonly seen after laparoscopic myomectomy, laparoscopic hysterectomy or use of morcellation. Limited literature currently exists on the incidence or prevalence of parasitic myomas following abdominal myomectomy or hysterectomy in the absence of morcellation. In fact, little is known about the pathologic mechanism of this disease process and its risk factors. We hope to highlight the complex laparoscopic evaluation, excision and removal of a symptomatic parasitic myoma identified twenty years after abdominal myomectomy without use of morcellation and thirteen years following abdominal hysterectomy in a patient with multiple prior abdominal surgeries.

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Laparoscopic Myomectomy of an Intraligamentary Myoma
Arquíelles Rojas S, Alfaro Alfaro J, Ayala Yáñez R, Flores Manjar MA. American British Cowdray Medical Center, Mexico City, Mexico

The study is about a laparoscopic myomectomy of an intraligamentary myoma. Myomas are the most common benign tumor on womans pelvis during reproductive age. These come from the myometrium cells and woman usually have pelvic pain and alterations in the menstrual cycle. The incidence is <1% of this type of myomas. In women during reproductive age, symptomatic and without satisfied parity the laparoscopic approach is preferred. This case is a patient of 31 years old, nulligesta, that begins with hiperpoly menorrhea. In the transvaginal ultrasound, we saw an intraligamentary myoma of 10 centimeters. We decided to make the laparoscopic myomectomy. During the surgery the uterus measured10x8x7 centimeters and we observed the presence of the intraligamentary myoma of 10 centimeters, having in the lower limit the right uterine artery at 1 centimeter. Myomectomy was completed laparoscopically without complications using the Morcellator, and the patient had no complications after the procedure.

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Single Incision Laparoscopy for a 30cm Ovarian Cyst
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This patient is an 18 year old G0, who presented with abdominal pain and distention. She was noted to have a 30cm ovarian cyst and was scheduled for ovarian cysctectomy. This video shows the versatility of the single-site platform. We demonstrate how to perform a challenging ovarian cystectomy while maintaining a minimally invasive surgical route and minimizing intraperitoneal spread. Due to the size of the cyst, we are unable to use a containment system and utilize the umbilical site for drainage. Next, using the single-site port, the cystectomy is started until the cyst can be brought through the port and the surgery is completed. Lastly, the delicate fimbrioplasty with salpingostomy can easily be performed extra corporally due to the larger surgical site. We also describe our closure technique when using the larger single incision site to avoid future hernia formation.

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Laparoscopic Management of a Large Paratubal Cyst
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Introduction: Paratubal cysts are a remnant of the Wolffian ducts. Most paratubal cysts are small and pedunculated in nature, Some paratubal cysts may be large and sessile in nature. Large paratubal cysts may be symptomatic and can lead to adnexal torsion.

In this video presentation we demonstrate the surgical technique of laparoscopic excision of a very large paratubal cyst with the preservation of the fallopian tube.

Case Description: A 20 year old G0P0 who was referred to our unit for evaluation of a large left adnexal mass. Her chief complaint was intermittent left lower quadrant pain for approximately 4 months. Ultrasound revealed an 8 cm left adnexal cystic structure.

Conclusion: Large paratubal cysts that stretch the fallopian tube in its surface can be safely excised laparoscopically without damage to the fallopian tube. Every effort should be made to preserve the fallopian tube in such patients who desire further fertility.

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Tips & Tricks: Vaginal Knife Morcellation in Alexis Bag (After Total Laparoscopic Hysterectomy for 18 Weeks Size Uterus) Made Easier with Titz Utero-Vaginal Manipulator
Titz H. Even Women’s Health, Brisbane, QLD, Australia

Food and Drug Administration (FDA) safety communication discouraged use of power morcellators for leiomyoma extraction after the case of disseminated leiomyosarcoma following a laparoscopic hysterectomy. In a review article, the risk of unsuspected sarcomatous change in hysterectomy specimens was 0.15% (1 in 650).

Case: A 43 years old patient was presented with the symptoms due to multiple fibroids (18 weeks size uterus). All pre-operative investigation did not suggest any malignancy. She has decided to have total laparoscopic...
hysterectomy, bilateral salpingectomy and vaginal knife morcellation in a bag after counseling and discussing different treatment options. Alexis contained extraction system (6500 ml by Applied Medical) was used. Patient had no intra or postoperative complications. Histopathology showed benign leiomyoma. This video shows followings:1. Tips and tricks on how to do vaginal morcellation in Alexis bag safely 2. How Titz utero-vaginal manipulator can help to overcome the challenges.

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Urinary Bladder Dissection in TLH in a Patient with Previous 3 Caesarian Sections
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Hysterectomy is the most often performed gynecological surgical procedure both in India and in the United States. Surgeon’s skills and newer techniques have developed since the first Lap. Hysterectomy was done by Harry Reich in 1989.

TLH in women with previous two or three Caesarian sections is common nowadays. This video shows how to tackle dense bladder adhesions in a woman with menorrhagia due to enlarged uterus with fibroid with previous three Caesarian sections.

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Laparoscopic Radical Parametrectomy for Cervical Cancer IB1 in Women After Prior Hysterectomy
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A 52-year-old Korean woman has undergone total LAVH due to CIS of cervix at another hospital. Since the histopathological report confirmed SCC of the cervix, the patient was referred to my hospital.

We performed a laparoscopic radical parametrectomy on March 3rd, 2016. Firstly, a laparoscopic exploration was done and then a bilateral pelvic lymphadenectomy was performed. After dissection of the bladder pillar, the vesico-vaginal space was joined to the paravesical space, completely separating the bladder from the anterior vaginal wall. The paravesical and pararectal spaces were developed and the cardinal ligaments were exposed. Both parametrial tissues were then resected from the vaginal route using linear endocut. Subsequently, a circumferential incision was made in the upper vagina. Both parametrium and upper vagina were pulled out through the vagina. The histopathological reports demonstrated no residual tumor in the specimen. After the operation, the patient has had no evidence of disease so far.

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Total Laparoscopic Hysterectomy Using Percutaneous Endoscopic Instrument
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A 48 years old woman was admitted with heavy vaginal bleeding. Endometrial biopsy was performed and endometrial hyperplasia with complex atypia was revealed out. Laparoscopic hysterectomy + bilateral adnexectomy was suggested. Final pathology was reported no evidence of cancer. Procedure was performed under general anesthesia in dorsolateral lithotomy position. After veress needle insertion, the abdominal cavity was insufflated with carbondioxide and pneumoperitoneum was obtained.

M-LPS was performed through one optical transumbilical 5-mm trocar, one 5-mm ancillary port on the right side, one 3-mm ancillary port on left and one 2-mm percutaneous endoscopic instrument. A 5-mm 0-degree endoscope, 3 mm laparoscopic instruments and integrated bipolar and ultrasonic technology (Thunderbeat, Olympus Medical Systems Corp, Tokyo, Japan) were used. All steps of hysterectomy and also vaginal cuff was sutured by using one 2-mm percutaneous endoscopic instrument (MiniGrip® Handle, Teleflex Inc. Wayne, USA).

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Laparoscopically Assisted Pelvic Adhesiolysis and Hysterectomy with Bilateral Salpingectomy in a Patient with Tuberculous Abdominal Cocoon: A Case Report
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Abdominal cocoon is a rare entity with an unknown aetiology. The extensive peritoneal encapsulation brings great challenges for surgeons. In this video we present the case of a 41-year-old female diagnosed with cervical squamous cell carcinoma IA1 had a past history of tuberculosis. Abdominal cocoon was incidentally discovered during surgery. The procedure of laparoscopic pelvic adhesiolysis and hysterectomy with bilateral salpingectomy were elaborated step-by-step. Key points to dissect through the plane of membranes covering the pelvic organs were shown, and techniques to avoid the trap of cocoon confusion were presented. The operation time was 2 hours with 50ml-blood loss. No intraoperative complications. No conversion to laparotomy. The patient recovered uneventfully during 1-year follow-up. With enough patience and delegate dissections following the landmarks of pelvic anatomy, surgeons may provide better results for patients with severe pelvic adhesion by performing mini-invasive laparoscopic surgery.

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Techniques for Laparoscopic Removal of Essure Coils
Schortz J, Lopez J, Keltz J, Chudnoff S, Levie M. Ob/Gyn, Minimally Invasive Gynecological Surgery Division, Montefiore Medical Center/Albert Einstein College Of Medicine, Bronx, New York

The Essure hysteroscopic procedure is a novel and useful technique for a minimally invasive approach to tubal sterilization. However, recently a number of chronic pelvic pain and acute pain, post procedure, have been reported. Case reports and studies have shown some improvement of such pelvic pain in patients after removal of the Essure device. The submitted video shows novel techniques utilizing transection of the fallopian tube as well as salpingostomy for the removal of Essure coils. Several surgical techniques utilized with laparoscopy are demonstrated in the video. The intended video may be used as instructional for practicing gynecological surgeons.

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A Rare Case of Inferior Vena Cava Variation
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Objective: To introduce a rare case of inferior vena cava variation in the para-aortic lymphadenectomy.

Methods: This is a 60 years old patient with ovarian clear cell carcinoma, stage Ila. Laparoscopic hysterectomy with bilateral salpingo-oophorectomy, omentum resection, pelvic and para-aortic lymphadenectomy were performed.

Results: A rare inferior vena cava variation was detected in the procedure of para-aortic lymphadenectomy. The operating time of para-aortic lymphadenectomy was 50 minutes. The estimated blood loss of the total surgery was 100mL. There were no conversions or perioperative and postoperative complications. The number of para-aortic lymph nodes was 12. The number of pelvic lymph nodes was 22.

Conclusions: Extreme caution should be taken to prevent the injury of inferior vena cava in the para-aortic lymphadenectomy.