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Gynecologic Oncology Department, The Maria Sklodowska-Curie Memorial Cancer Center, Warsaw, Poland

O-1

A review of the use of "Essure" outpatient hysteroscopic female sterilization in a provincial hospital in Ireland.

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"Essure" outpatient hysteroscopic female sterilization is a relatively recent development in Ireland. Up to now almost all female sterilization procedures have been carried out under general anaesthesia via laparoscopy, which carries infrequent but potentially serious risks.
We will present our experience of 58 patients on whom we have carried out this outpatient procedure in our small provincial hospital over the past 2 years. We will present our selection policy and medical preparation and will analyse the numbers of successful and unsuccessful attempts and the reasons for failure in the latter cases and changes made in response. No pregnancies have to date been reported.
All patients were reviewed after 3–4 months and all were subsequently sent a detailed questionnaire to determine their opinion of the experience of the procedure. The analysis of these questionnaires will be presented in detail together with samples of their comments.

O-2

A systematic review of the accuracy of magnetic resonance imaging (MRI) in diagnosing endometriosis

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Objective: To perform a systematic review to evaluate the role of MRI in diagnosing endometriosis. Materials and Methods: Medline (1966-2003) and Embase (1980-2003) databases were searched for relevant papers. Study selection, methodology assessment and data extraction were conducted in a systematic way. Sensitivities, specificities, positive and negative predictive values and likelihood ratios (LRs) were calculated for each study, against visual inspection at surgery as reference standard. A LR+ >10 or LR– <0.1 were taken to indicate that MRI had a large impact on the likelihood of disease being present or absent, and a LR+ of 5-10 or LR- of 0.1 to 0.2 signified a moderate impact. Results: Fifteen of 75 studies identified satisfied selection criteria, but data could be extracted for analysis from only 10. MRI was helpful in establishing the diagnosis in one study (LR+=47.99) and in excluding it in two studies (both LR-=0.0). In four studies, either the LR+ or LR- was incalculable. This implies MRI has a low impact in the diagnosis of endometriosis and contradict clinical opinion regarding its utility. Conclusion: Reasons for the low yield of suitable studies for analysis and their disappointing findings are discussed. Our results have implications for the design of future trials assessing non-invasive diagnostic methods for this condition.

O-3

Laparoscopic treatment of recto-vaginal septum endometriosis.

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Objective: To analyse the outcome of the treatment of recto-vaginal septum endometriosis.
Design & Methods: We included 31 patients, since August 1999 and June 2003, with a mean age of 31 years with recto-vaginal septum endometriosis. The mean time for diagnosis was 4.5 months. All the patients had pain (pelvic pain: 26-83.8%, dyspareunia: 22-70.9%; dyschezia: 16-51.6%), eight patients (25.8%) had diarrhoea or rectal tenesmus, and five (16.1%) had hematochezia. Laparoscopic surgery was performed in 26 patients (83.3%), of which 6 (23%) had to be converted to open surgery. In 9 cases, a low rectal resection with termino-terminal anasthomosis had to be practiced. In the rest of the patients only tumorectomy was needed. Endometriosis was histologicaly confirmed in 26 (83.8%) patients. These patients were followed for 6 to 68 months. 25 patients were free of disease, in 5 the endometriosic tumor had decreased in size, and in one case the disease remained the same. The symptoms disappeared in 24 (77.4%) patients, decreased in 4 (12.9%), and remained the same in 3 of them.
Conclusions: Laparoscopic surgery is an appropriate approach for the treatment of recto-vaginal septum endometriosis. More analytic studies, comparing it to open surgery, should be performed.

O-4

Experience in Córdoba (Spain) with Essure in a consulting room (more than 700 cases)

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Objectives: To demonstrate that the Fallopian's tube occlusion by hysteroscopic approach with Essure (TM) can be carried out in an easy way and without hardly nuisances neither complications for the patient in a consulting room, and that it is the real alternative to the Fallopian's tube occlusion by laparoscopia. **Material and methods:** Up to the 31 of July 2004, 716 Fallopian's tube occlusion with ESSURE in the hysteroscopic consulting at the Hospital Universitario Reina Sofía, Córdoba (Spain) have been carried out. The patients were included in two groups, with or without anaesthesia and/or analgesia. Results: Bilateral device placement was achieved successfully in 98.6% of the cases, and unsuccessfully in 1.4% (10 cases). When valuing the degree of difficulty in the placement of the devices, 84.7% of the cases was classified as low or medium difficulty, and only 15.3% as high difficulty. 84.7% of the women qualified their experience of Essure (TM) placement as no or scarcely painful. Complications have not taken place during the procedure. The women recovered their normal activities the day of the placement in 75.3% of the cases. They reported to be very satisfied in 91.6%, and 8.4% satisfied. **Conclusions:** The Fallopian's tube occlusion by hysteroscopic approach by means of the method ESSURE in a consulting room is a reality nowadays.

O-5

"Tension free" procedure with IVS posterior tunneller as minimally invasive surgery for vaginal vault prolapse

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The purpose of this study is to describe a minimally invasive surgical procedure to correct vaginal vault prolapse. In a prospective one year follow up study, we used IVS tunneller for posterior approach (*Tyco Healthcare*, USA), to treat 9 patients (7 with vault prolapse, 4 after vaginal hysterectomy, 3 after abdominal hysterectomy; and 2 with recurrent uterine prolapse after failed Manchester-Shirodkar operation The study protocol included preoperative: medical history, gynecologic examination, urodynamics, perineal US for imaging pelvic floor, QoL was assessed. For 2 patients this procedure was performed after LAVH (Laparoscopically Assisted Vaginal Hysterectomy) for recurrent uterine prolapse after Manchester-Shirodkar operation. The anesthesia was at regional type for pure IVS procedure, and endotracheal for concomitant LAVH. Patients were followed up at 1, 3, 6, 12 months after surgery. The mean patient age was 63 years (42-72), operation time for IVS posterior was 45 minutes (35-65), blood loss was 80 ml (50-100 ml). There was no intra operative rectal injury. Tape rejection was no found. The technique is safe, minimally invasive with shorter operation time, use spinal anesthesia, faster convalescence by short hospital stay and resumption of usual activities at home and employment.

O-6

Laparoscopic ligation of internal iliac arteries for gynecological diseases.

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We have assessed the efficacy of laparoscopic ligation of internal iliac arteries as an alternative method of treatment of patients with uterine myoma, adenomyosis and cervical pregnancy. 24 women with uterine myoma and adenomyosis aged 33-53 and 14 patients with cervical pregnancy were examined and underwent laparoscopic ligation of internal iliac arteries with unsolved thread. After this stage we performed endoscopic laser-induced interstitial thermotherapy in patients with adenomyosis, endoscopic myomectomy in patients with uterine myoma and vacuum-aspiration of the conceptus from the cervical canal in patients with cervical pregnancy. There were no intraoperative complications, blood loss even during myomectomy didn't exceed 100 ml. The follow-up period was 6-18 months. All the patients had normal menstrual cycle. During ultrasound examination with Doppler sonography we noted the decrease of uterine size and blood supply. None of the patients needed subsequent radical surgical treatment during the follow-up period. Thus, laparoscopic ligation of internal iliac arteries can be a good clinical practice for treatment of patients with uterine myoma, adenomyosis and cervical pregnancy.

O-7

Spraygel barrier and prevention of adhesions after laparoscopic surgery

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Objective: After adhesiolysis and fertility promoting operations adhesion (re)formation might be reduced by separating surfaces. An ideal barrier should be effective in preventing adhesion formation, be resorbable and easy applicable, also during laparoscopy. SprayGel, a resorbable polyethylene glycol barrier showed a significant reduction in adhesions and can be used through the laparoscope. To study this barrier a study was undertaken.Design and methodsTwo arm prospective, double blinded, randomised controlled study including 30 patients that undergo laparoscopic treatment of the ovaries, pelvic sidewall or tubes. Patients are randomised to routine treatment (rinsing with Ringer's lactate) or to Spraygel barrier. Second look laparoscopy is performed within 6 weeks. Adhesion formation is scored (extent, severity, enclosure and type) at both procedures. Student T-test and Wilcoxon two-sample test are used.ResultsTill so far 16 patients have been included in the study. The reduction in adhesion incidence, local adhesion score for all organs and local adhesion score for the adnexa from initial surgery to the second-look was highly significant for the SprayGel treated patients as compared to the controls. SprayGel was easily applicable due to the spraying system and blue dye.ConclusionsSprayGel is a very promising and easy applicable barrier that showed a significant reduction of adhesion (re)formation in this interim analysis of 16 patients.

O-8

A unique etiology of nipple discharge!

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Introduction: Five percent of the patients presenting to a symptomatic breast clinic have nipple discharge. Breast duct microendoscopy (BDME) is a new technique, which helps evaluate the underlying cause of nipple discharge. It is possible that microendoscopy may bring to light some alternative etiologies for nipple discharge helping us to a better understanding of the clinical conditions presenting with nipple discharge.We describe a case of nipple discharge with a unique etiology! Report: A 47 years old lady presented with copious serous discharge from a single central duct on the left nipple for few months. BDME was performed under local anaesthesia. All the ducts showed erythema with frond formation, which in our experience are signs of inflammation. In the distal part of one of the ducts a loose plug of black material was seen. Irrigation with saline dislodged short fragments of dark hair. A lavage cytology sample was collected which showed fragments of a ribbon like foreign body with surrounding and adherent inflammatory cells. BDME was repeated after six months. This time there was evidence of fibrosis, perhaps reparative, but no more foreign bodies. Discussion: The hair like foreign bodies that were identified in this case had a flat ribbon like shape, bi-refringent under polarised light and were unlikely to be human hair. Other possibilities are wool, synthetic fibres or pet hair. BDME has helped to avoid unnecessary open surgery in this case.

O-9

Endometrial polyps. Should they be treated?

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The purposes of this study were to determine the rate of benign, hyperplastic and malignant EP, to establish the correlation between hysteroscopic versus histologic EP, to compare the clinical data and histological outcome, and finally to solve the enigma: should we remove all the lesions diagnosed as EP. Over an 8 years duration [01Jan 1995–31 Dec 2002], 1035 hysteroscopies have been performed.EP were diagnosed in 174 patients.A=the fertile, B=the perimenopausal and C=the postmenopausal.

Group	No- EP	Histology- EP		
		Benign	*Hyperplasia*	*Malignant*
A	29	21 [72.4%]	7 [24.1%]	1 [3.5%]
B	64	52 [81.3%]	7 [10.9%]	5 [7.8%]
C	81	62 [76.5%]	16 [19.7%]	3 [3.8%]

Group	Hystero. EP	Histological EP	Correlation
A	29	21	72.4%
B	64	52	81.2%
C	81	76	93.8%

Group	Routine exam.	Infertility	DUB
A	23 [79.3%]	5 [17.2%]	1 [3.5%]
B	49 [76.5%]		15 [23.5%]
C	54 [66.7%]		27 [33.3%]

EP malignancies arise among the symptomatic patients only!. We conclude that removing the non symptomatic ET is unnecessary.

O-10

Effect of desiccation upon adhesion formation in a laparoscopic mouse model.

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Objectives: Pneumoperitoneum (PP) can cause desiccation in the peritoneal cavity which produces cooling. Desiccation is widely accepted as a co-factor in adhesion formation (AF). The pure effect of desiccation upon AF i.e. without associated cooling remains unexplored, and was addressed in our laparoscopic mouse model. **Design & Methods:** Adhesions were induced in mice (n=45) during laparoscopy. A homeothermic blanket was used to keep mice at 37°C. Desiccation was induced by flow rates of 0, 23 and 100 ml/min through the abdomen and non-humidified CO2 for the PP. For the highest flow, humidified gas in mice at 37°C and non-humidified gas in hypothermic mice (without blanket) were also evaluated. **Results:** AF increased with desiccation ($p<0.01$, Wilcoxon). Using humidified gas or hypothermia, AF returned to baseline levels (no-flow group). **Conclusions**: Desiccation increases AF. Hypothermia and humidified gas reduce AF. Understanding the interrelationship between desiccation and cooling will help to design new humidifiers/insufflators to minimise AF.

O-11

Effect of temperature upon adhesion formation in a laparoscopic mouse model.

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Objectives: CO2 pneumoperitoneum (PP) is a co-factor in adhesion formation (AF). PP can cause desiccation in the peritoneal cavity which decreases body temperature (BT). The specific effect of the associated cooling upon AF remains unexplored, and was addressed specifically in our laparoscopic mouse model. **Design & Methods:** Adhesions were induced in mice (n=86) during laparoscopy. Animals were placed at different environmental temperatures and BT was strictly controlled. **Results:** Anaesthesia, an environment with lower temperature, ventilation with non-humidified air and the PP all decrease BT. In animals with a lower BT, AF is lower ($p=0.004$, Pearson). AF increases with the duration ($p=0.01$) and decreases with the addition of 3% of oxygen to the PP ($p=0.03$) at 37°C (Mann Whitney). **Conclusions**: Hypothermia reduces AF, which supports PP-induced hypoxia as a driving mechanism in AF, since hypothermia decreases the toxic effects of hypoxia and/or of the ischemia-reperfusion process. These data could open new possibilities for adhesion prevention in laparoscopic surgery.

O-12

Role of green filter in adenomyosis hysteroscopic diagnosis

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Objective: The purpose of this study is to determine, by using a modified hysteroscopic approach, an early diagnosis of adenomyotic foci. **Design & Methods:** two groups of fertile patients have been selected at the Department of Obstetrics, Gynecology and Reproductive Medicine of the II University of Naples: A) n=30 patients with a previous uterine surgery (cesarean section, myomectomy or curettage) performed at least one year before for benign condition; B) n=28 controls. All patients underwent a diagnostic hysteroscopy. The light source had a green filter interposed to identify the vascular endometrial design. **Results:** the green filter allowed the detection of hysteroscopic different pictures consistent with adenomyosis diagnosis. A dark irregular area with shape and starry surface are indicative of adenomyosis focus. Multiple ramifications of hypertrophic vessels are sometimes associated. In presence of a previous uterine surgery, the adenomyotic foci appear as a fibrotic area within the hysterotomic scar. **Conclusions:** we have found higer rate of adenomyosis after cesarean section or curettage. The use of green filter in hysteroscopy allows the early detection of adenomyosis, thanks to the detailed images of uterine vascularization.

O-13

Laparoscopically enucleated leimyoma located on the old caesarean section scarr

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A case of myoma uteri located on the old caesarean section scarr.
History: Mrs. F.A 37 years old and married for six years. In the year 2000 she underwent histeroscopic septum resection followed by an another revision operation in 2001. She got pregnant in 2002 belaboured with caesarean section. Two years later due to the complaint of menometrorrhagia the patient applied to our clinic and a myoma with subserous and intramural component was diagnosed by ultrasound in 38×45×47 mm diameter located on the ischtmic part of uterus.Laparoscopic myomectomy operation was planned.
Technique: Two lateral trocars 5 cm above the symphisis and 8cm lateral to the midline, another 10 mm trocar at the umbiliculus inserted into the abdominal cavity under general anaesthesia. After laparoscopic myomectomy the defect of incision line closed using extracorporeal suture technique with three 2.0 vicryls. Myoma is taken out of the abdominal cavity with morcelator and after bleeding control the operation was ended without complication. The patient was discharged the day after the operation.
Conclusion: As to our knowledge myoma originating from caesarean section scarr is very rare. Laparoscopy is a good choice for removal of this kind of myomas.

O-14

Balloon dilatation of the uterine cervix - a novel, safer and less traumatic approach to cervical dilatation for Endo-uterine surgery

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The tightly closed uterine cervix poses an obstacle for the surgeon intending to perform Endo-uterine surgery. Laminaria tents take hours to dilate the cervix and the result is at times imprecise and incomplete. Thus the main modality in use remains the sequential insertion of increasing caliber rods. This method puts the cervix at risk of damage, false route, perforations and cervical incompetence. **Objective:** Developing a safer, efficacious and less traumatic method of cervical dilatation. **Description of the method:** A 2.5 mm diameter, semi rigid, 8 cm long device that may be inflated to a fixed, exact and predetermined diameter of 10 mm is inserted through the cervical os and then inflated to the full and exact diameter with water. **Results:** To date we performed 10 cervical dilatations in women undergoing intra uterine surgery (Operative hysteroscopy or termination of pregnancy). All cases were successful with no complications or side effects. Conclusion: We hypothesize that as opposed to the advancing front method of Hegar dilatation, this uniform dilatation is safer, and gentler on the uterine cervix. We will also present a video of the method and real time sonography of the device dilating the cervix.

O-15

Further data on laparoscopic myomectomy. A nine years experience.

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Objective: Our purpose is to describe the indications, feasibility, complications and final outcome of laparoscopic myomectomy.
Material & methods: Case series study of 134 patients who underwent laparoscopic myomectomy from October 1994 to December 2003. The number of myomas was 184 (range: 1-5 per patient). The main indications were: infertility or sterility in 54 cases (40,3%), abnormal bleeding in 35 cases (26,1%), pain in 17 cases (12,6%) and increase of size in 7 cases (5,2%).
Results: Postoperative fever was seen in 4 cases, significant bleeding in 8 cases (only 2 blood transfusions), and no visceral lesions were reported. Conversion to laparotomy was necessary in 22 cases (16,4%) due to multiple myoma (6 or more) in 9 cases (41%), large size in 7 (31,8%), technique difficulty in 4 (18,1%), and other causes, in 2 patients (9%). Twenty of 54 patients that desired future pregnancies became pregnant (37%), with 3 resulting in miscarriage. Caesarean rate was of 17.6% (3 cases). No uterine rupture was observed. We reported recurrences in 6 patients (4,47%); 5 of them underwent subtotal hysterectomy.
Conclusions: Laparoscopic myomectomy is a feasible and safe technique with a very low rate of complications and recurrences.
Reproductive outcome seems similar to another patients without any previous uterine surgery.

O-16

New tension-free sub-uretral tape procedure

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Vaginal treatments of urinary stress incontinence, using prosthetic tapes became gold standards because of their effectiveness. Tension-free Vaginal Tape was the first of these procedures, Trans Obturator Tape is now widely used too. Apparently simple they bear some severe complications, early (visceral lacerations) or delayed (urinary retention, mesh fistulization, pain). This work was done to to study the feasability, limits and effectiveness of an innovating procedure of sub-uretral tape with the advantages of earlier procedures without their risks or complications (Placed Retro Obturator Prosthesis, PROP). A polypropylene tape is placed by a single vaginal way following a new technique, and with specific instruments in USI patients. There is only one sub-uretral incision unlike in other techniques. The parameters studied were: intra and post operative complications and short term effectiveness. Thirty-four patients were included. The follow-up ranged from 3 to 12 months. The procedure was easy in every case. Results were considered as excellent 28 times, very good 2, good 1, under average 2, nil 1. There was no complication. Early results of the PROP are as good as those of gold standard procedures. It's simplier, and easily reprodicible, with a lower early and delayed complication rate. There is no risk of visceral laceration, or urinary retention. Larger studies are needed to assess these results, but it seems it will have an important place.

O-17

Essure tubal sterilisation technique at Chu Bichat: how our practise has evolved

Dr Dhainaut, Pr Madelenat. CHU Bichat C.Bernard. Paris.

Essure has been practised in our hospital since 2002. Over the years our clinical practise has positively evolved.
Many different elements make up clinical practise: patient preparation, operative environment, patient stress, hysteroscopy technique, anaesthetic regimen etc. Every one of these elements can have an influence on the clinical outcome. In our case we have very positively influenced our results by changing some key elements in our methods, thanks the interactions we have had with other Essure users, most importantly in area of anaesthetic regimen, patient preparation and hysteroscopic technique.
We introduced changes such as: "no anaesthesia", menstrual timing, NSAID before procedure, and the Bettocchi no speculum technique (also called *vaginoscopy*)
These changes have had very positive impact. Our occurrence of vagal reactions (some up to half hour following the procedure) has fallen from almost 30% down to nil. The procedure time has been reduced and patient satisfaction is much higher.
Better clinical practise has helped us operate in a truly outpatient and minimally invasive fashion. When practised in this way, Essure represents a true advance in women's health and a cost saving for our health care system.

O-18

Evaluation of the recurrence in moderate-severe endometriosis

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The aim of this study is to analyse the variables relatives to recurrence in moderate-severe endometriosis and the making-up of a mathematic model to estimate the survival function. **Material and Methods.** Since 1995 to 2003 we performed laparoscopic surgery to 199 patients with moderate-severe endometriosis. 100 of them were stage III and 99 stage IV (AFS-r classification). For the recurrence analysis we used 7 categorical variables: size of endometrioma, location of endometrioma, kind of surgery, associate gynaecological disease,postoperative treatment with GnRH agonists, surgery before (a) and after (b) year 2000. **Results.** The number of recurrences was 24 patients (12% of cases non-censured data, and the remaining cases were censured score, age of patients and parity. The statistical method was the Cox Regression, using a forward method. data. The significant variables included in the survival function model were: AFS score; date of surgery and size of endometrioma. The resulting formula was: S(t) = (S0(t))0,024AFS –1,257 size (2) +1,485 date For each patient of the study with moderate-severe endometriosis, the survival function resulted of 8.5% recurrence rate in 5 years. ConclusionsThese results suggest that this statistical model could be useful to evaluate the possible recurrence moderate-severe endometriosis.

O-19

Endometrial polyps: A study of prevalence in a general population.

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Objective: To assess the prevalence of endometrial polyps in a general population. **Methods:** Two hundred women were recruited for exami-nation by a random selection from the Danish Civil Registration Sy-stem. 428 women were invited, 332 responded and of these 200 wo-men were eligible for examination. Age was 30-59 years (mean 44). Endometrial thickness and the uterine cavity were evaluated by trans-vaginal ultrasound scanning and by hydrosonography, respectively. Hysteroscopic resection was performed in cases with intrauterine processes. **Results:** Mean endometrial thickness (MET) was 5,5 mm. (range 0,6-13,2) for premenopausal women. Postmenopausal women had MET 3,0 mm. (range 1,3-9,0). By hydrosonography intrauterine processes were diagnosed in 27 cases, the MET in these women was 6,1 mm. (range 2,1-12,2). Histology showed 21 intrauterine polyps (10,5 %) and 6 submucosal fibroids (3%). **Conclusions:** In 200 randomly selected women the prevalence of uterine polyps was 10,5 percent. The clinical implication of uterine polyps is still unsettled.

O-20

The Hysterosocopic Morcellator, a new technique for the removal of endometrial polyps and submucous myomas.

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Objective: The purpose of this pilot study was to assess the performance and safety of a new hysteroscopic operating technique.
Methods: 50 patients were recruited and treated in 4 gynaecology departments in Europe. A new surgical device, 35 cm in length, was inserted in to a straight working-channel of a 9 mm hysteroscope. The major advantages are: the use of saline and the removal of the tissue fragments through the instrument.
Results: The mean operating time was 5.6 min. for polyps and 15.2 min. for myomas. The overall mean operating time was 9.8 min. The mean amount of fluid deficit (saline) was 196 mL. for polyps and 871 mL. for myomas. The overall mean fluid deficit was 448 mL.
The mean surgeons rating (VAS, range 1=poor - 10=excellent) score of easiness and performance of the technique was 9.2 for polyps, 7.3 for myomas and 8.4 overall. All procedures were uneventful.
Conclusion: This new technique for the removal of endometrial polyps and submucous myomas may offer a safe and effective alternative to conventional resectoscopy.

O-21

Vaginal Assisted Laparoscopic Suspension of Prolapse isolated of Vaginal Cupola

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Background: The prolapse of the vaginal cupola after abdominal or vaginal hysterectomy is a frequent find in the gynaecological practice. if isolated, without urinary stress incontinence or marked prolapse of the rectum or elitrocele, the surgical choose may be a extra-peritoneal insertion of a polypropylene graft fixed centrally to the cupola and laterally to the fascia lata, close to the iliac spine. in same cases is duty to close the douglas cavum by accosting uterus-sacral ligaments to the median line and suturing the posterior parietal peritoneum. Aim of study: although we have experienced the total laparoscopic approach, the aim is to demonstrate a progress in feasibility, efficacy and safety of the laparoscopic extraperitoneal suspension of the graft assisted with a fixation by vaginal route.

O-22

Preemptive port site local anesthesia in gynaecologic laparoscopy: a randomised double-blinded controlled trial.

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Objective: To assess the impact of preemptive infiltration of port sites with local anesthetic on postlaparoscopy pain. Method: A total of 170 women scheduled for gynecologic laparoscopic procedures were randomly assigned to preincisional infiltration with ropivacaine (n=86) or with saline solution (n=84).Infiltration with either local anesthetic or placebo was accomplished in each port site before skin incision. All patients underwent a standard anesthesia induction and maintenance. Results: Postoperative pain was evaluated with visual analogue scale and patients interview at 1, 3 and 24 hours after surgery. No difference was found between groups in pain levels, pain location and in the site of superficial pain at any of the postoperative time periods. The proportion of women requiring analgesia before discharge was similar in the local anesthetic group and in the saline group [22/86 (25.6%) vs. 19/84 (22.6%), P=0.72]. The analgesic consumption in the first 24 hours after surgery and the time to first analgesic request did not differ significantly between the two groups.
Conclusion: Preemptive infiltration of trocar sites with ropivacaine is not effective in postoperative pain relief.

O-23

Surgical experience for the treatment of infertile patients in a reproductive department. A retrospective study of the period 1998-2003.

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Objectives: We present a single center five-year experience in the surgical treatment of infertile patients. The type of surgical procedures and the complications are described.
Design and methods: Between January 1998 and December 2003, 675 abdominal surgical procedures were done in our department. In all, the operations performed were diagnostic laparoscopy (22%), diagnostic hysteroscopy (11%), operative hysteroscopy (14%) and operative laparoscopy (42%). Laparotomy was performed in 11% of patients, being the main indications history of more than two major abdominal surgeries or the presence of a myoma over 10 cm of size. Laparoconversion rate was 1,5%.
Results: The results of the operations in these 675 patients are described. The mean hospitalization period was 2,3 days, with a total incidence of complications 2,2%, no death occurred. Short-term and long-term results are also described.
Conclusions: We consider the laparoscopic approach in patients with infertility to be feasible and safe in experienced hands. It provides diagnostic accuracy as well as therapeutic capabilities. Sparing patients laparotomy reduces hospitalization, cuts health care costs, and improves cosmetic results.

O-24

Hysteroscopic treatment of uterine septum and reproductive outcome in patients with or without recurrent pregnancy loss.

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Objectives: To describe the reproductive outcome of uterine septum according to the presence of recurrent pregnancy loss.
Design and methods: A retrospective analysis of 47 uterine septum treated by hysteroscopic septoplasty. A first group of 17 patients (A) with the diagnosis of previous recurrent pregnancy loss (RPL) were compared with 30 patients (B) with no previous RPL.
Results: Both groups were comparable in terms of age, BMI and time of infertility. The müllerian malformations were identified as uterine septum (71% in A; 72% in B) or uterine subseptum (29% in A; 28% in B). The diagnosis was suspected by ultrasound or hysterosalpingogram, the sensitivity for the diagnosis was 69% and 71% respectively. The mean follow up was 26,7 (A) and 24,5 months (B). Pregnancy rate was 35% in A and 43% in B. The pregnancy loss was first trimester miscarriage (17% in A vs 33% in B) and 2nd trimester miscarriage (33% en A vs 25% en B). A live newborn was obtained in 50% of pregnancies in A and 33% in B.
Conclusions: Uterine septum is a frequent müllerian malformation in women with recurrent pregnancy loss. Ultrasound and hysterosalpingogram allows a correct diagnosis in over 2/3. Hysteroscopic septoplasty allows, in 50% of women in the group of RPL, to obtain a good reproductive outcome.

O-25

Laparoscopic myomectomy: technique, complications and reproductive outcome

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Objectives: To describe the laparoscopic myomectomy technique, the complications and the reproductive outcome of these patients. **Design and methods:** 44 laparoscopic myomectomies were performed in patients for infertility (79%), pelvic pain (15%) or abnormal uterine bleeding (6%). Mean follow up of 13,4 months. **Results:** 112 myomas were removed. The variables studied were (mean ±SEM): number of fibroids (2,5±0,2), size of the largest fibroid (5,1±0,3 cm), type of myomas (60,1% intramural; 39,9% subserosal), distortion (29,6%) or opening the endometrial cavity (9,5%), myomas TTT 4 cm (76,9%), operating time (122,5±7,3 min), decrease in Hb (2,9±1,1 g/dl), hospital stay (50,1±9,5h), time of analgesia (29,4±4,2h), time of ileus (25,8±4,8h). Laparoconversion was required in 3 patients, two due to intraoperative hypercapnia and one due to excessive bleeding. Postoperative complications were a severe anaemia requiring a blood transfusion and two cases of pyrexia. 10 of the 34 patients that were infertile became pregnant (29%). The mean delay in conception was 6,2 months. 6 live newborns were delivered, 2 miscarriages occurred and 2 pregnancies are in course. No dehiscence of uterine scar occurred.
Conclusions: Laparoscopic myomectomy is an effective and safe procedure. It has a low risk of complications and appears to be a valid alternative to the open procedure with the advantages of short hospital stay, fast recovery, and reduced time of analgesia.

O-26

Laparoscopic surgery for ovarian masses in postmenopausal women

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In the not too distant past, all postmenopausal women with an ovarian mass ("Palpable ovary") were regarded as candidates for total abdominal hysterectomy with bilateral salpingo-oophorectomy (TAH+BSO). During the past 5 years 159 such patients were seen at our department. Of these, 34 underwent laparatomy for high suspicion of ovarian cancer (ultrasonic appearance, tumor markers and the presence of ascites). The remaining 125 patients underwent laparoscopic bilateral salpingo-oophorectomy (BSO). The specimen were removed (usually in an endobag) and sent for frozen section for pathological examination. In 10 cases the intra-operative pathological examination revealed carcinoma of the ovary and the patients underwent immediate TAH+BSO with complete staging for ovarian cancer. In 115 women the procedure and postoperative course were uneventful. We conclude that once the highly suspicious postmenopausal patients are excluded, laparoscopic BSO is the optimal mode of treatment provided an intra-operative pathological examination is always carried out and a proper gynecological oncological service is available for the immediate continuation of onco-gynecological surgery and staging when necessary.

O-27

Hysteroscopic sterilization with Essure(r). Three years follow-up.

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Objectives: Evaluate changes in the menstrual cicle, pelvic pain, pregnancy rate and degree of satisfaction with the Essure(r) procedure. **Design & Methods:** We present 62 patients that proceed from two prospective clinical trials which are part of a multicentric trial. We have evaluated the degree of satisfaction, changes in the menstrual cycle, dysmenorrhea, menstrual flow and adverse events after three years of using Essure (**Results:** A total of 50 patients remained after the exclusions (lost cases and placement failures). The average age was 38 years (30-49); 14% of them (7) presented alterations in their menstrual cycles as spotting or amenorrhea. Regarding dysmenorrhea, none of the patients informed about increases or decreases of their menstrual pain. Six patients (12%) informed about changes in their menstrual flow. The grade of satisfaction, it was rated as excellent or very good by all the patients. Only 4 patients presented gynaecologic adverse events. After 2,185 woman-months of exposure to intercourse, no pregnancies have been recorded. **Conclusions:** Essure(r) method doesn't cause any changes in dysmenorrhea. Changes observed in menstrual cycle, menstrual flow and the adverse effects are similar to the general population. The satisfaction degree is high and there are no pregnancies reported.

O-28

Optimization of indications to laparoscopic myomectomy

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The aim of this study was to compare a myomectomy by laparoscopy with that by laparotomy and its intra- and postoperative course and long-term effects. METHODS: This was a retrospective study of 222 women who underwent myomectomy in our Clinic between January 1992 and December 2000. RESULTS: In the laparoscopic group, subserosal myomas, less than 50 mm in diameter were mainly removed, but in the open group - intramular myomas, larger than 70 mm in diameter. In the post operative course there were: less percentage of anaemia, fewer transfusions, lower febrile morbidity, shorter antibiotic and analgesic therapy time, lower frequency of postoperative complications and shorter hospital stay in the laparoscopic group compared with the open one. CONCLUSION: To laparoscopic myomectomy should be qualified patients with: history of infertility, preoperative uterine size at the most 10 gestational weeks equivalent in gynaecological examination, and 1 to 3, subserosal myomas, at the most 50 mm in diameter found in ultrasound examination. If these criteria are kept, the laparoscopic myomectomy will be a safe and effective procedure.

O-29

Laparoscopic supracervical hysterectome: 12-year experience

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To minimize the surgical trauma we performed 1500 laparoscopic supracervical hysterectomies using a special technique with a loop ligature since 1991 till now. The three-puncture technique was used. After bipolar coagulation of the round ligaments, the utero-ovarian ligaments, the isthmic portion of Fallopian tubes or the infundibullo-pelvic ligaments these structures were transected by scissors. Vesicouterine peritoneum was dissected, the posterior leaves of the broad ligaments were opened. A special loop ligature was put at the level of the interior os. The uterine vessels were coagulated above the ligature, the uterine corpus was cut off by scissors. The operating time was 65(28 min. There was no intraoperative bleeding, no trauma of the bowel, bladder or the ureters, no need for hemotransfusion. The estimated blood loss was systematically less than 150 ml. The follow-up period was between 6 months to 12 years. We did not note any cases of cervical stump cancer or cases of urinary incontinence. In the late postoperative period patients' satisfaction by surgery was high and achieved 97,6%. Thus, the supracervical hysterectomy seems to be less traumatic than the total hysterectomy and prevents such complications as intraoperative trauma of urinary bladder and ureters and postoperative sexual dysfunction.

O-30

Microwave endometrial ablation and bowel injury.

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Background: Microwave Endometrial Ablation (MEA) is a technique employed for Dysfunctional Uterine bleeding (DUB). It is believed to be safer, quicker and easier to perform. To our knowledge,there has been only one reported case of a serious complication of a bowel injury during MEA. We report another similar case of accidental uterine perforation and bowel injuries Case-report: A 32 year old lady presented with symptoms of irregular, heavy periods. Clinical examination, hysteroscopy, ultrasound were unremarkable. It was decided to perform MEA. Patient also wanted to be sterilised at the same time. She therefore was listed for an MEA and a laparoscopic sterilisation..MEA appeared uncomplicated and the MEA temperature readings were normal. However at laparoscopy a full thickness burn to the uterus was identified and because of this, following sterilisation, bowel was inspected and there were two burnt areas, in the ileum and in the anti-mesenteric edge of the sigmoid colon. Immediate General Surgical help was sought and laparotomy was performed. A loop of small bowel was resected and a wedge resection of the affected part of the sigmoid colon was performed. Post operatively the patient made an excellent recovery. Histology revealed focal areas of necrosis in muscularis propria and focal mucosal damage in both the small bowel and in the wedge of sigmoid colon.

O-31

The predictive value of pre-operative pelvic ultrasound in women with chronic pelvic pain

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Objective: To determine whether pre-operative clinical examination and pelvic ultrasound predict the outcome of laparoscopy in women with chronic pelvic pain (CPP).
Design & Methods: A retrospective analysis of case notes of 501 women who had laparoscopy for CPP in an inner city university hospital between January 1997 and December 2003. Using laparoscopy as the reference test, positive predictive values (PPV) were calculated for clinical examination (n=251), pelvic ultrasound (n=175), or a combination of both (n=83).
Results: 501 out of 1260 (39.8%) diagnostic gynaecological laparoscopies were performed for CPP. Laparoscopy was negative in 163 women (32.5%) but in others, revealed endometriosis (105, 21%), adhesions (103, 20.6%), endometriosis and adhesions (54, 10.8%) or pelvic inflammatory disease (31, 6.2%). The PPV of clinical examination, ultrasound and clinical examination plus ultrasound were 69%, 79%, and 81% respectively.
Conclusion: Only two-thirds of women with CPP would have detectable pathology at laparoscopy, but clinical examination alone cannot reliably predict such women. In order to justify the anaesthetic and surgical risks of laparoscopy, all women with CPP should be evaluated pre-operatively by both abdomino-pelvic examination and pelvic ultrasound, and counselled appropriately using the PPV of these assessments.

O-32

Questionnaires on Quality of Recovery in Gynecology

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Objective: The evaluation of medical interventions has been shifted towards patient orientated outcomes. When introducing non-invasive surgery the question is whether the recovery of the patient is better. However, proper instruments to measure the recovery after gynecologic surgery are lacking. Myles et al. developed a questionnaire to measure quality of recovery (QoR-40). The aim of the present study is to assess whether this tool is useful for the evaluation of gynecologic interventions.
Design and method: The questionnaire was filled in by 563 women. We categorized into a laparotomic-, a laparoscopic- and a non-intervention group. The mean QoR was calculated at 8 moments in the first 12 weeks after surgery. Repeated measures analysis of variance was used to establish changes in QoR-40 over time (time effect), differences in QoR-40 between the groups (treatment effect), and interaction between changes in QoR-40 over time and treatment group (time by treatment effect).
Results: The total QoR-40 score for all operative patients shows a significant change only over time (time effect p(0.001). Conclusions: The QoR-40 is a potentially valuable instrument for follow up of postoperative recovery. In this group no positive effect of endoscopic surgery could be measured. Further validation for gynecologic interventions might overcome this problem.

O-33

Use of micro-brush for precise sampling of intraductal lesions of the breast.

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Introduction: We report first successful use of breast duct microendoscopy(BDME) and micro-brush to collect cytology samples under direct vision. **Materials and methods:** (BDME) was offered to all patients undergoing surgery for nipple discharge. It was carried out under local or general anaesthesia using 0.9 mm and 1.1 mm microendoscopes. The 1.1 mm scope has 0.45 mm working channel, which can be used to insert brush. The brush was used to collect samples from visualised endoluminal lesions. Patients with intraductal papillomas visualised on Endoscopy were randomised to lavage cytology with brush or ductal lavage cytology only. The morphological findings on endoscopy were correlated with the final histopathology report and brush cytology report. **Results:** Intraductal papillary lesions were seen in 10 cases. Seven patients had brush cytology and lavage and three patients had ductal lavage only. Five out of seven patient in first group showed clusters of papillary cells on cytology whereas none of the three cases in group two showed papillary cells. Papilloma was confirmed on histopathology report in all 10 cases. **Conclusion:** Use of brush markedly increases the sensitivity of cytology. We are currently investigating the role of micro-brush to detect pre-invasive malignancy in suitable patients with high risk.

O-34

Laparoscopic management of interstitial ectopic pregnancy.

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Objective: Report of effectiveness of minimally invasive surgical treatment of unruptured interstitial ectopic pregnancy. Methods: A 34 years old pregnant woman presented with mild RIF pain and normal increasing serial levels of serum beta HCG. Diagnostic laparoscopy a few hours after admission identified a 4 cm right uterine fundal/interstitial mass. Attempted conservative laparoscopic treatment was decided: a safety double monocryl hemostatic suture was placed below the ectopic mass, but not tied. Prophylactic homolateral salpingectomy was performed. Endoloop was applied at the base of the ectopic pregnancy followed by incision with bipolar forceps and removal of the mass. Haemostasis was achieved by intraflecting extracorporeal suture reinforced by ligation of the 2 sutures earlier placed. Methotrexate 50 mg was given the next day to minimize the risk of persistent ectopic pregnancy (PEP). Results: No intra-operative or post-operative complications were noted. No blood transfusion was required as post-operative haemoglobin levels were 12.5 g/l at 8 hours, 11.5 g/l at 36 hours and discharge. Beta HCG levels showed a normal drop pattern at post-op day 1, 6, 9, 12 and 30. Follow up at 7-30-90 and 180 days showed a full asymptomatic recovery and normal pelvic ultrasound at 6 months. Conclusions: Laparoscopic treatment of unruptured ectopic pregnancy is possible in selected cases. Advanced minimally invasive surgical experience is required.

O-35

Results of a French experience about 100 cases with Essure performed with and without local anesthesia.

Patrice Lopes

Objective: To compare the feasibility, efficiency, tolerability, pain, duration of hysteroscopic placement of intra-tubal devices (ITD) with and without anesthesia. Design: Retrospective comparative study in Nantes University Hospital France. 100 patients for tubal sterilisation by the hysteroscopic way. 2 periods: T1: 2/2002-9/2003, 70 procedures with paracervical anesthesia. T2: 9/2003-6/2004, 30 patients, without any anesthesia. Results: No pregnancy has been reported with more than 1400 months of exposition. Mean age: 41,2±3,3 vs 39,4±3,5. Parity:2,6±0,8 vs 2,7±0,7. The bilateral success rate of placement for the first attempt was 86,6% vs 90%. A complement of anesthesia was performed in 25,7% of the patient in T1(18 general anesthesia) vs 10% in T2 (2 general anesthesia and 1 l PCB for dilatation of a stenotic cervix). Mean time elapsed between the start of anesthesia for T1 and the beginning of hysteroscopy for T2 and removal of optics was 24,6±9,3 vs 12,0±4,1 mn (range 13-57 vs 6-27). The maximum pain was 5,2±1,8 vs 4,7±2,6. Conclusion: The hysteroscopic sterilisation is feasible and sure. The procedure without anesthesia is quicker and painless. Nowadays, by the hysteroscopic way, tubal sterilisation does not require anesthesia and hospitalisation.

O-36

Distance of myoma from perimetrium as qualifying criterion to hysteroscopic myomectomy in cases of myometrium deep penetrated myomas – transvagonal sonography versus sonohysterography (SIS)

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Objective: width comparision of free part of myometium above myoma assessed by SIS or by conventional transvaginal sonography and influence of these assessment on qualifying procedures. **Design:** Study group:45 women with myomas that deep penetrate myometrium qualified to hysteroscopic myomectomy. At all women SIS and conventional sonography were performed, especially distance between myoma and perimetrium was measured. On basis of our own and other authors' observations width of myometrium over myoma >5 mm was qualifying to hysteroscopic myomectomy. **Results:** By using of both method the difference in width measurements were stated. Widening of uterus cavity by liquid during SIS changed topography, stretched muscular fibres over myoma and decreased distance from uterus perimetrium. There may totally change qualifying proceedings in cases of myomas located close to perimetrium **Conclusions:** SIS allows assessing distance from perimetrium in anatomical conditions like these during hysteroscopy. Using in such cases TV sonography can be insufficient and can be the reason of uterus wall perforation during hysteroscopy.

O-37

Outpatients hysteroscopy (OHS) under control of transrectal ultrasonography(TRUS) - the new method of diagnostics of uterine cavity pathologies after hysteroscopic electrodestruction of endometrium.

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Objective: Presentation and value assessment of OHS under control of TRUS as diagnostic method of uterine cavity assessment at women after hysteroscopic electrodestruction of endometrium. **Material and methods:** Study group: 29 women with performed OHS and biopsy with associated TRUS. Control group: 26 women with performed OHS without TRUS. Rresults of performed procedures in both groups were compared. (OHS with TRUS vs. OHS) Statystical analysis: Chi2, student and Mc Nemar tests. **Results:** Illustrating of suspected area was recognized as satisfactory in 25(87%) cases vs. 10(36%) in control group. Complications are only in control group in 3(11,5%) cases alleged canal, in 1(3,8%) case perforation of uterus. **Conclusions:** Simultaneous application of OHS and TRUS allow imaging and biopsy performing these areas of uterine cavity that cannot be reach by hysteroscopic optics for the sake of numerous adhesions after endometrial destruction procedures. In cases of partial or total occlusion of uterine cavity, "blind performed" biopsy or biopsy only under control of hysteroscopy can be reason of overlooking of significant pathology.

O-38

Transrectal intraoperative ultrasonography (TRUS) accompanying hysteroscopic operations with increased risk of uterine wall perforation

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Objective: value assessment of TRUS in monitoring of hysteroscopic electroresection of myomas that deep penetrate myometrium and hysteroscopic synechotiomy in Asherman's syndrom. **Design and materials:** Study group-hysteroscopic operations with intraoperative TRUS-submucosal myomas in stage G2 by ESH and intramural myomas (n=43), total Asherman's syndrom.(n=6) Control group- without TRUS- hysteroscopic myomectomy (n=47), synechiotomy in Asherman's syndrom (n=5) Parameters characterizing of hysteroscopic operations, complications, and anatomical results after operation. were compared. Statistical analysis Chi2 and t student tests. **Results:** When TRUS was used (in contrast to control group) no intraoperative no complications were observed and mean time of procedure was decreased: myomectomy (24vs36 min), synechiotomy in Asherman's syndrom (29 vs. 38 min). **Conclusions:** Usage of TRUS increases safety of operations, and causes optaimalization of course parameters and anatomical results in cases of hysteroscopic resection of submucosal myomas deep penetraeted myometrium or intramural, and in advanced Asherman's syndrom.

O-39

Reduction of Adhesions Following Laparoscopy with Oxiplex®/AP Gel

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Objectives: Oxiplex®/AP Gel was developed for adhesion prophylaxis during minimally invasive surgery. Design and Methods: Randomized, 3rd party blinded, parallel-group design conducted at 4 centers. Pts. (18-46 yrs. old) underwent laparoscopic surgery with 2nd look 6-10 weeks later. Oxiplex/AP Gel was applied as a single coat over adnexa and adjacent tissues. Blinded reviews of videotapes were used to quantitate American Fertility Society adhesion (AFS) scores. Results: Treated adnexa (n=44)showed a decrease in AFS Score 11.9 to 9.1. In contrast, control adnexa (n=42)showed an increase in AFS Score (8.8 to 15.8). The differences in 2nd-look AFS Scores (59% reduction) and change between 1st and 2nd-look (89% reduction) were significant ($p<0.01$). Conclusion: Oxiplex/AP Gel was safe and easy to use via laparoscopy and produced significant reduction in adnexal adhesions.

O-40

Long term follow up of Hydrotherm Ablation of Endometrium (HTA) for heavy menstrual bleeding - follow up of 255 cases over 5 years

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Heavy menstrual bleeding accounts for 30% of consultations to the gynaecological department. Around 60,000 hysterectomies are carried out in the UK every year for benign gynaecological pathology. Roughly 30% of these are for dysfunctional uterine bleeding (DUB). Amongst the second generation techniques available for treatment of DUB, Hydrotherm Ablation (HTA) provides a safe, easy to perform and effective method of ablating the endometrium. The results of 350 cases performed over a 5 year period will be presented. Data regarding the effectiveness of HTA in achieving amenorrhoea and light periods will be addressed over a 5 year follow up. Analysis of the effect of HTA on polyps and submucous fibroids and data on repeat HTA will be analysed. The hysterectomy rate for failed HTA will be analysed with the relevant histology results. Complications of the procedure will be discussed.

O-41

Effectiveness and safety of LigaSure" vs conventional coagulation in laparoscopic hysterectomy

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The present study investigated the effectiveness and safety of the coagulation system LigaSure®, which should have some advantages in comparison with conventional energy-based systems, in terms of thermal spread to the surrounding tissues (reduced from 2 to 0.5 mm), and in terms of effectiveness. Thirty patients undergoing laparoscopic hysterectomy were randomly assigned to 2 study groups in which either (n=15) LigaSure®, or (n=15) monopola/bipolar conventional coagulation systems were used for vessel sealing. In the LigaSure® group the average time for a supracervical hysterectomy was reduced by 13 minutes (from 68 to 55) with respect to the traditional methods, whereas the time was reduced by 15 minutes (from 75 to 60) for total hysterectomy. The average blood loss was reduced on average from 150cc to 75cc by using the LigaSure® system. No complications were registered for any of the 30 patients, either during surgery or in the postoperative period. These preliminary data confirm that the use of LigaSure® significantly reduces the duration of both total and subtotal laparoscopic hysterectomy and the amount of blood loss during such procedures. Furthermore, the LigaSure® system requires minimal dissection, in terms of vessel isolation from the surrounding tissues, making its use appealing even for less experienced surgeons.

O-42

Suggested Certification Model for Endovascular Procedures for Obstetrician-Gynecologists

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We sought to advance a scheme which can be adopted by different countries to credential obstetrician-gynecologists to perform endovascular procedures. Such a program would generate a document for presentation to hospital committees supporting an application for privileges. We formulated a review of other specialties learning endovascular procedures. The shell of the similar proposals includes completion of a didactic course, being proctored in a fixed number of cases, and certification in fluoroscopy safety. Two paradigms of endovascular credentialing are appropriate for comparison: cardiology standards for coronary artery interventions (Circulation 1992; 86:1348-50) and vascular surgery standards for endovascular stint placement (J Vasc Surg 1999; 29: 177-86). Both require a course including laboratory and participation in 100 cases, 50 of which as primary operator. In addition, many countries require a certificate of fluoroscopy safety. A credentialing board will be created to verify both the standards and completion of course requirement and proctored cases. Obstacles to training include resistance from other specialties, malpractice insurance coverage, and an inability to perform endovascular procedures in other countries or states. Credentialing will benefit both patients and obstetrician gynecologists who will be able to provide continuity of care not currently available. The gynecologist will be able to manage all complications, which cannot be done under current circumstances.

O-43

Laparosocpic surgery and histologic verification of endometriosis

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Objectives: We correlated the laparoscopic findings of endometriosis with the histologic confirmation of the disease over a period of 2 years. The study was performed at the Department of Obstetrics and Gynaecology, Campus Kiel, University Hospitals Schleswig-Holstein. **Design & Methods:** 164 laparoscopies performed at our department over a period of 2 years were reviewed for laparoscopic findings and histologic confirmation of endometriosis. The number of laparoscopies performed for stages I, II and III lesions, according to the AFS classification, is given. **Results:** The majority of patients suspected of endometriosis at laparoscopy were confirmed by histological examination i.e. 138 out of 164 patients (84.1%). **Conclusions:** Laparoscopy is the easiest diagnostic tool for the diagnosis of endometriosis which can be confirmed by histological examination.

O-44

Who should follow-up the patients after special endoscopic operations?

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Objective: To investigate the long-term history of patients after hysteroscopic myomectomy in respect whether the follow-up were done by the operating surgeon or by the doctor who referred the case for operation.
Design and methods: Data of 59 patients were analysed. Patients were followed up for one to ten years. Further management and outcome was compared in respect whether the patients were followed up by the surgeon or by a different doctor.
Results: Myomectomy have been done on 32 patients, myomectomy with endometrial resection on 27 women. Within ten years period eight patients (17%) had hysterectomy due to inadequate symptoms relief, 38 (83%) women were satisfied with the result of the operation. Thirteen patients wanted to be pregnant; nine of them had ten pregnancies carried to term within five years. Six caesarean sections were done for obstetrical reasons, but partly because of the previous hysteroscopic myomectomy. The majority of the patients who underwent further operation (hysterectomy-75%, caesarean section-36%) were followed up by the doctor who referred the case for the initial operation.
Conclusion: Patients after special endoscopic operations should be followed up by the surgeon performed the procedure to avoid further unnecessary non-minimally invasive operations.

O-45

Use of the LigaSure™ vessel sealing system in Gasless laparoscopic hysterectomy.

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Objectives: To evaluate the safety and the effectiveness of a new electrothermal bipolar vessel sealer (LigaSure™ Atlas, Valleylab, Boulder, CO, USA) during gasless laparoscopic hysterectomy using a subcutaneous abdominal wall lifter called LaparoTenser®.
Design & Methods: From January 2002 to June 2004 we treated 60 patients. Twenty patients underwent to a laparoscopically assisted vaginal hysterectomy and 40 to a total laparoscopic hysterectomy. The LigaSure™ vessel sealer system incorporates Valleylab's patented Instant Response™ technology, which diagnoses the type of tissue in the instrument jaws and delivers the appropriate amount of energy needed to effectively seal it. The more recent version of the system for laparoscopic use, called LigaSure™ Atlas permits not only coagulating, but also cutting the tissue.
Results: The median operation time was 94.5±25. The avarage drop in hemoglobin was 2.1±0.8. No conversions to open surgery or blood transfusion was necessary.
Conclusions: The LigaSure(tm) Atlas and Gasless laparoscopy permit performing laparoscopic hysterectomy, without increasing risk, and improving the compliance of patients and sanitary structure.

O-47

The comparison of laparoscopy and laparotomy in the treatment of endometrial cancer

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Study objective: to compare results and clinical outcome in patients treated with laparoscopy and laparotomy for endometrial cancer. Design and methods: Retrospective analysis of 45 patients treated with laparoscopy and 136 treated treated with laparotomy. Methods of statistical analysis: the comparison between two groups were done using the t-test for normally distributed variables and Kolmogorov-Smirnov and Mann-Whitney tests for other variables. The disease free survival (dfs) in both groups was compared using log-rank test. Results: There was no significant statistical difference in the rate of recidives in the both group (p=0,249) nor in disease free survival (p<0,052).There was no significant statistical difference in complication rate (p<0,147). Operation time was significantly longer for laparoscopy (120 versus 90 min) and the hospital stay shorter (5 days versus 7 days).There was no significant difference in the number of removed lymph nodes with using both surgical methods. The median intraoperative blood loss was similar in laparoscopy and laparotomy (p=0,128).
Conclusions: Laparoscopy is the safe method of surgical treatment in endometrial cancer.The risk of recidive do not depend on the method of the operation.Although the operation time is longer with laparoscopy but the postoperative stay is shorter.

O-48

Successful pregnancy after endometrial carcinoma treated by hysteroscopic ablation

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Endometrial cancer is considered the most common cancer of the female genital tract in developed countries. It is primarily neoplasm in postmenopausal women. The average age of the patients is around 55-60 years and only 5% of the cases are women younger than 40.Yet, the trend of younger patients with endometrial cancer has been reported.
We report a case of endometrial neoplasm in a woman aged 30 who is suspected to be the carrier of hereditary non-polyposis colon cancer (HPNCC) pedigree, and our conservative treatment of the patient with her agreement.
Carcinoma of the endometrium was diagnosed after hysteroscopic polypectomy. Because of her age and strong desire for pregnancy conservative therapy of repeated hysteroscopic endomyometrial biopsy, combined with gestagen therapy was performed. Three months after the therapy she reached a pregnancy. There is a need for individual approach in young women with endometrial carcinoma and unfulfilled motherhood.

O-49

Vaginal aplasia associated with anatomically and functionally normal uterus

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Maldevelopment of vagina is usually combined with aplasia/hypoplasia of uterus (Mayer-Rokitansky-Kuster-Hauser syndrome). Complete vaginal aplasia with normally developed uterus and cervix is extremely rare case of development failure. Accepted treatment for this kind of maldevelopment is hysterectomy with formation of neovagina.
We present case of 12-year-old girl with isolated complete aplasia of vagina, and symptoms of cyclic menstrual-like abdominal pain that began 11 months before the admission to the hospital. After the creation of vagina during the first procedure and lysis of pericervical adhesions with implantation of skin graft in second procedure, she has regular menstrual bleeding through the 9 cm long and 3 cm wide vagina.
Isolated aplasia of vagina with functional uterus may be treated successfully by creation of neovagina with partial skin graft.

O-50

Laparoscopic occlusion of uterine vessels the alternative treatment of symptomatic fibroids

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Leiomyomas of uterus are one of the most common tumors of the female reproductive system. They occur in 20% - 40% of women aged over 35 and may cause symptoms like menorrhagia and dysmenorrhea. The most popular and conventional treatment for symptomatic fibroids has been till now hysterectomy or myomectomy. The alternative to those kinds of treating is laparoscopic occlusion of uterine vessels, especially for women who want to preserve their uterus. Our purpose was to evaluate the effects of laparoscopic occlusion of uterine vessels in treating symptomatic fibroids. We studied 11 women aged 36 to 50 years old with symptomatic uterine fibroids. Patients were qualified to laparoscopic occlusion of uterine vessels using harmonic scissors. Before the operation and 5 days after uterine and the dominant fibroid were measured by ultrasonography and their volumes were calculated. The average volume of uterus and dominant fibroid were reduced by 15,4% and 37%, respectively. There were no complications during and after operation. It was well tolerated, with a short hospital stay and rapid recovery. In our opinion laparoscopic occlusion of uterine vessels is a safe and promising method for treating symptomatic leiomyomas. Further investigation is needed to evaluate change in clinical symptoms.

O-51

Office hysteroscopy in postmenopausal bleeding: diagnosis and treatment in one session

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Objectives: In postmenopausal women with an endometrial thickness of more than 4 mm. intracavitary pathology is diagnosed in more than 50% of the cases. In this group of postmenopausal women we describe the use of office hysteroscopy which can be used as a diagnostic and therapeutic tool in one session (see and treat). **Design and methods:** From January 2002 -until December 2003 patients visiting our clinic with postmenopausal bleeding and an endometrium thickness of more than 4 mm measured by ultrasound, were scheduled for hysteroscopy. This cohort of postmenopausal women undergoing hysteroscopy was evaluated. Hysteroscopy was performed in 186 patients. Hysteroscopy was performed in an office setting, using a vaginoscopic approach. If a polyp was visualised this polyp was removed in the same session (see and treat) using the Duckbill polypsnare. **Results:** During hysteroscopy in 85 (50.6%) patients intracavitary pathology was diagnosed. In this group with intracavitary pathology 75% was treated in the same session (polypectomy). In 16 patients of this cohort (9,5%) an endometrial carcinoma was diagnosed. **Conclusion:** Office hysteroscopy in women with postmenopausal bleeding offers the possibility of diagnosis and treatment in one session.

O-52

Small uterine septum does not behave benignly.

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Two hundred fifty nine (259) singleton deliveries in the group of women with a large septum (septum length 1.5-7.5 cm - AFS 5) and 265 singleton deliveries in the group of women with a small septum (septum length 1.2-1.5 cm - AFS 6) were evaluated. The perinatal data before surgery in 68 singleton deliveries of the large and in 75 singleton deliveries of the small septum group were compared to 191 deliveries after surgery of the large and to 190 deliveries of the small septum group. After surgery the preterm birth rates decreased from 40% to 8% in the large septum group, and from 41% to 10.5% in the small septum group P<0.0001. The gestational age <32 weeks was reduced from 17.6% to 3.6% in the large septum group and from 13.3% to 5.2% in the small septum group (P<0001) and the gestational age 32-37 weeks from 23.5% to 4,7% in the large septum group and from 26.7% to 5.2% in the small septum group (P<0001). Intensive care referral rate was reduced: from 30.4% to 8.4% and from 24.6% to 7.9% respectively (P<0.000) and fetal stillbirth and neonatal mortality from 13.2% to 3.1% in the large septa and from 10.7% to 1.1% in small septum group (P<0.01). The small uterine septum was evidenced as an important hysteroscopically preventable perinatal risk variable. The revision of existing classification of uterine anomalies would therefore be mandatory.

O-58

The impact of adhesions in laparoscopic operations duration

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The objective of this study is to find out how adhesions influence the duration of an adnexa cyst laparoscopic extraction.
The design in order to perform this purpose was based on 34 women having one-sided adnexa cyst and submitted to the above operation. For every woman the operation duration in minutes and the degree of adhesions presented in the operational field was written down. The fields were distributed according to the degree of adhesions into one of these 4 categories: without adhesions, with few or simple adhesions, with multiple or diffuse adhesions and cysts attached by solid adhesions. The kind and size of cysts were not taken into consideration.
The method followed was that of regression analysis of the variables, as well adhesions being used as dummy ones.
The results was not satisfactory (p=0.641), nor the partial findings: Few adhesions extend the mean duration by 14% than without these (p=0.331), multiple adhesions extend the mean duration by 1% than few ones (p=0.416), and solid adhesions accelerate (!) the mean duration by 20% than multiple ones (p=0.866).
The conclusion is that such a hypothesis perhaps is correct but a greater sample of women and along the consideration of other variables is needed for this.

O-59

Improval of success rates in Essure” procedure: The experience of 442 cases.

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Objective: To evaluate factors which may influence success rates in Essure” procedure.
Design and methods: Retrospective observational study of 442 cases of Essure® procedures during a two-year period in two Spanish hospitals. Vaginohysteroscopic approach without anesthesia was performed in 355 cases (80.3%).
Results: Success rate reached 96.2% (425/442). All failures (17/442), except for one, happened during the first third of the cases. Patients’ satisfaction was referred as “good” in 95% of the procedures. At third-month follow-up, more than 95% of the patients would not have chosen to be submitted to the procedure under anesthesia.
Conclusions: Our success results (96.2%), mean operative time (9.8 minutes) and recovery time (20 minutes) were statistically better (91%, 14 minutes and one hour, respectively) than in literature’s. We recognize two main factors influencing the outcome of the Essure® procedure. On one hand, the learning curve of the technique. On the other hand, the experience in diagnostic hysteroscopy. Conversely, neither anesthesia, architectural abnormalities, oral contraception or past history of cesarean section seemed to be responsible for failures.

O-60

Hysteroscopic Tubal Sterilization with the ESSURE System: A Clinical Update

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Female tubal sterilization is one of the most commonly used methods worldwide for permanent contraception. The majority of such procedures are performed by laparoscopy or mini-laparotomy. The quest to simplify tubal sterilization has been elusive. Recently, a new method of transcervical tubal sterilization called the ESSURE Permanent Contraceptive System was developed by the California-based company, Conceptus, Inc.
Clinical evaluations prior to premarketing approval in 879 women who selected hysteroscopic permanent contraception with ESSURE micro-inserts showed a bilateral occlusion. At six months follow-up, bilateral occlusion was demonstrated in all patients. The ESSURE method was approved by the FDA on November 4, 2002.
The preliminary clinical trials and extended experience since FDA approval have shown promising results for pregnancy prevention, with no significant association seen in morbidity, making the method an excellent option for women seeking permanent contraception.

O-61

Concomitant ESSURE Tubal Sterilization and Therma-Choice Endometrial Ablation: Feasibility and Safety

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The majority of women undergoing endometrial ablation for uterine bleeding are of reproductive age. To evaluate the feasibility, effectiveness, and safety of combining ThermaChoice III endometrial ablation (EA) and the Essure sterilization method in one setting,40 women requiring a hysterectomy for abnormal uterine bleeding were recruited to consent to the performance of both procedures before their hysterectomy. The extirpated uteri were evaluated visually and histologically. To evaluate safety of heat transmission to surrounding organs during EA, thermocouples were placed along the serosa of the proximal tubes and uterus after Essure placements. No disturbance of the Essure devices was noted and the endometrial ablation by the ThermaChoice was judged to be complete and uniform. Measured temperatures were safe. The results of a combined performance of Essure and ThermaChoice EA offer a promising and safe one step approach for women requiring endometrial ablation and tubal sterilization.

O-62

Pain mapping

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Objective: to evaluate the findings of laparoscopic conscious pain mapping in women complaining of pelvic pain.
Methods: seven consecutive women with chronic pelvic pain had conscious pain mapping. Operative findings were evaluated using visual analogue scale (VAS). All procedures were performed as office laparoscopy and local anesthesia with neuroleptoanaesthesia. The access provided by laparoscopy have permitted as well the treatment pelvic adhesions, and dye passage through the fallopian tube.
Results: First, anatomic observation was performed: no abdominal and pelvic pathology was found. Five out of seven women mapped pain specifically to visceral structure, with ovary outlined in 4/7 (VAS: 7) , uterus in 2/7 (VAS: 5), bladder in 2/7(VAS: 6) as the most common. Chronic visceral pain syndrome and adhesions were the most common findings diagnosed.
Conclusion: conscious pain mapping can be done with in women before surgical evaluations and treatment of chronic pelvic pain.

O-63

Ultrasound instead of Hystero Salpingo gram to control successful Essure placement??

Vleugels mph, (1) Reinders s, (1) Veersema b. (2)
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The new device for hysteroscopic sterilization consists of a nitinol spring, curled around a central catheter. The spring has to be unloaded in the intramural part of the tube.; the spring fixates itself and the polyethylene terephtalate fibers in its centre. The reaction, creates fibrosis, occlusion of this part of the tubes within 12 wks. Thus, sterilization will be effective after 3 months unless we are convinced that the device is placed correctly; Control of. blockage of the tubes can be checked by Hystero Salpingo Gram,the golden standard to test tubal patency, but transvaginal ultrasound control of the position could be sufficient. The value of ultrasound localizing Essure related to HSG has been analyzed in a prospective study (n=125); correct placement correlated with the HSG; pos. predictive value 1.00 (95%; 0.99-1.00), sensitivity 0.93 (0.95%; 0.90-0.97), specificity 0.83 (0.95%; 0.54-1.13).When a device is not seen inside the outer line of the uterus or there is doubt about the position, this negative finding correlated with HSG; neg. predictive value 0.24 (0.95%; 0.06-0.42).Pos. predictive value; 0.99 (0.95%; 0.91-1.00), neg. predictive value 0.07 (0.95%; 0.06-0.19.
Summary; we can conclude that by use of the transvaginal ultrasound in 91% of all women an HSG is not necessary to proof effectiveness of the Essure occlusion of the tubes.

O-64

Management of patients (200) for Essure sterilisation

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The new hysteroscopic sterilization method Essure has been developed to simplify definitive female sterilization This new approach requests for another management of patients and doctors/personnel. In Essure, patients will be aware of what is done in her body; she has to accept impressions never experienced before, feelings she does not knew before, some discomfort and sometimes pain// cramps. She accepts these experiences since she has chosen the advantages of this method on the OPD; non anaesthesia, non admission, rapid recovery, no scars. But, she can only give her commitment on the condition; she dictates her limits to the surgeon. Her limits will be extended enough for the surgeon to perform the sterilization unless we help her to extend these limits by the following Information; Instruction to personnel; small Iinstruments like “Bettochi” 4.9 mm,(Storz) introduced without dilatation. This I.I.I. has led to the management of patients as shown in the video clips and in the detailed slides This specific management of patients (n=200) resulted in an overall pain score VAS of 2.7 even less then during menstrual periods and a procedure time less then 10 minutes. Without exception all woman mentioned on the quality life questionnaire that they would advocate this method to any else, even those who had failure of placement.

O-65

The influence of partial septate uterus on the incidence of spontaneous abortion

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Several retrospective observational studies show that uterine septa have bad reproductive outcome with an increased incidence of early abortions as high as 44.3% to 79%. In those studies mostly women with a difficult reproductive history were studied. We were interested in the incidence of uterine septa (AFS 5 and 6) and its connection to spontaneous abortion in a population of women who had hysteroscopic evaluation of the uterine cavity due to other reason than reproductive health problems. 157 women (53.9±10.8 years) visited our outpatient hysteroscopy (HSC) office because of bleeding disorders, ultrasonographically suspected endometrial pathology or because of missed IUD. In all of them a diagnostic HSC was performed. In 14% we found a septate uterus. 9.6% of all women reported spontaneus abortion. The number of spontaneous abortions was higher in the group with septate uterus compared to the other group (0.6±0.9 vs 0.1±0.5, p=0.0001), the abortion rate was 22.7% to 7.4% respectively (p=0.024). There were no differences regarding age and number of deliveries between both groups. None of the patients was treated for infertility.Our study shows that septate uterus increases the risk of spontaneous abortion, but our percentage of spontaneous abortions in women with septate uterus is not as high as reported in other studies. We think that further studies are needed to elucidate this data.

P-1

Use of fibrin glue for mesh fixation in laparoscopic and vaginal surgical treatment of pelvic floor disorders.

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Objective: The aim of this work is to report the results of a series of operation for pelvic floor disorders treated with prosthetic mesh. The potential complications due to the risk of migration led to consideration of an alternative method of fixation using fibrin sealant.
Design & Methods: We have studied 5 patients treated with laparoscopic colpo-promonto-fixation for vaginal vault prolapse and 12 patients treated for I.U.S. with TVT device. In this series Tissucol was used for fixing the mesh. We have compared this treatments with our previous experience without fibrin glue.
Results: The patients in which we used fibrin sealant had less bleeding, shorter intervention time and hospital stay.
Conclusions: The application of human fibrin glue (Tissucol) to fix prosthetic mesh reduces the local morbidity, lessens the severity of complications and shortens hospital stay.

P-2

Nonsurgical diagnosis of ovarian endometriosis

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Objective: to correlate the diagnosis of endometriosis with symptoms, signs, tumor markers and ultrasound findings.
Design & Methods: In a prospective study at Civic Hospital Di Cristina and M. Ascoli we selected 102 women to undergo laparoscopy or laparotomy for ovarian cyst. The group was interviewed before surgery about dysmenorrea and dyspareunia. Each member had pelvic examination, a transvaginal ultrasound and serum determination of Ca125. At surgery endometriosis was noted and endometriomas were removed by stripping the cyst wall from ovary and were analysed by pathologist. **Results**: clinical sign, tumor markers and ultrasound all likely correlate with histologically confirmed ovarian endometriosis. **Conclusions**: non invasive tools may be used to reliably identify women with ovarian endometriosis.

P-3

Different surgical approaches to hysterectomy: surgeons challenge or clinical reality?

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Objective: We sough to assess the surgical approach to hysterectomy in the clinical practice, according to uterus weight.
Method: The records of consecutive hysterectomy (VH, LH or TAH) performed for benign disease were reviewed. All procedures were performed by 3 experienced surgeons. The surgeon's choice between the different surgical approaches and the perioperative complications were analysed according to the uterus size.
Results: A total of 206 procedures met the inclusion criteria (57.8% VH, 25.2% TAH and 17% LH). The 3 groups were similar with regard to patients age, BMI, parity, previous abdominal surgery and concurrent procedures. Similarly, there was no difference in the demographics when the study population was divided according to the uterus weight (≤400 g or >400 g). A significantly lower proportion of women underwent a THA in the former group than in the latter. No significant difference was found between the two groups either in intraoperative (2.1% vs. 3.0%, p=0.66) and postoperative complications (2.9% vs. 6.0%, p=0.28], blood transfusions and reoperations. The abdominal route was favored more frequently with increasing uterus weight (p for trend=0.03).
Conclusions: A cautious use of laparoscopic and vaginal approach seems a prerequisite to minimize complication rates in women with large leiomyomatous uteri.

P-4

Outpatient operative hysteroscopy: pain score analysis with and without local anesthesia

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We compared the pain felt by patients undergoing outpatient operative hysteroscopy using the traditional technique with local anesthesia and those with "no touch" hysteroscopy, without the use of anesthesia. A retrospective analysis was carried out of the charts of 146 women submitted to operative hysteroscopy on an outpatient basis. 84 procedures were performed with paracervical injection of 1% lidocaine and the next consecutive 62 procedures were performed without the use of any anesthesia. We used a 5.5 mm continuous flow hysteroscope system (Olympus) with a 5 french working channel (with the use of scissors, graspers and bipolar device-Versapoint®). Pain was rated on a visual analogue scale from 0 to 10 at the end of the procedure. The statistical analysis was performed with student's t-test. Pain scores were statistically significantly higher without the use of anesthesia especially in postmenopausal women and when polipectomy or multiple procedures were performed. However, the difference in mean pain scores was always less than or equal to 3 making us question the use of local anesthesia. Overall, operative outpatient hysteroscopy is a well tolerated procedure. We feel that perhaps in pre-menopausal women operative outpatient hysteroscopy without anesthesia is an acceptable procedure that obviates the possible complications of local anesthesia.

P-5

Analysis of hysteroscopies of patients taking tamoxifen

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We evaluated the results of the outpatient hysteroscopies of patients receiving tamoxifen as adjuvant therapy for breast cancer. A retrospective analysis was performed of the charts of 89 patients all with abnormal sonograms; only 8 were symptomatic. We used a 5.5 mm continuous flow hysteroscope system with a 5 french working channel. In 86 cases samples were collected for histological analysis. The mean patient age was 61.2 years (range 30-83), 69 (77.5%) were post-menopausal. The average cumulative dose of tamoxifen was 19.9g (0.6-36g) and the average duration of treatment was 2.4 years (1 month - 5 years). The following pathology was found: 49 (56%) endometrial polyps, 10 (11.2%) cases of atrophic endometrium, 3 (3.5%) adenocarcinomas, 3 (3.5%) cases of hyperplasia (1 simple, 1 cystic, and 1 atypical), 2 endocervical polyps, 1 leiomyoma, and 1 uterine septum. 20 women had done hysterosonograms and in 90% the results correlated with the final diagnosis. In the 8 symptomatic patients we found: 4 endometrial polyps, 2 atrophic endometriums, and 2 endometrial carcinomas. The results found favor that the patients under tamoxifen must do regular transvaginal ultrasound as a screening method for detection of endometrial pathology. We found a good correlation between hysterosonogram and hysteroscopy. Hysteroscopy is a powerful method for the diagnosis and treatment of endometrial pathology because it provides a direct view of the lesion and enables guided biopsy/removal of the lesion.

P-6

A new hysteroscopic method for female sterilization

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The most widely used methods for female sterilization are simple tubal ligation, electrocautery of the fallopian tubes, and occlusion by clips. We studied the safety and effectiveness of essure, an expanding nitinol (titanium, steel and nickel) implant to be placed transcervically. The dacron fibers placed inside the essure device induce fibrosis, which occludes the fallopian tubes in a three months period, resulting in permanent female contraception. Since march 2003 till march 2004 18 previously fertile women underwent hysteroscopic sterilization. The procedure was performed under intravenous sedation or local anesthesia. After 3 months a hysterosalpingogram was performed to confirm tubal occlusion. Bilateral device placement was achieved in 16 of the 18 women (88%) who underwent placement attempts. All women found the procedure to be highly acceptable. All women were discharged the same day of the procedure and returned to normal function within the day after. Three months after placement, correct microinsert placement and tubal occlusion were confirmed in 15 women (93,7%). Hysteroscopic tubal sterilization with essure is well tolerated and allows a rapid recovery, an high patient satisfaction, and is effective alternative to laparoscopic sterilisation.

P-7

Preoperative antibiotic prophylaxis in laparoscopic management of an ovarian cysts during pregnancy: open prospective non comparative study

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The aim of the present study was to determine the efficacy and safety of amoxicillin-clavulanic acid as preoperative antibiotic prophylaxis in laparoscopic management of an ovarian cyst during pregnancy. During a 5-year period, 35 laparoscopic procedures were performed in patients with an ovarian cysts during the second trimester of pregnancy. All patients received amoxicillin-clavulanic acid (2.2 g) as a single dose 60-120 minutes before surgery. Each patient was assessed daily until discharge to evidence febrile status and the presence of infections at the operative site, urinary and respiratory tracts. Infectious complications were infrequent with febrile morbidity occurring in only one patient (2%). No signs of infections at the surgical site, urinary and respiratory tracts were observed, no death due to sepsis was recorded. The mean hospital stay was 10.8 days. The outcome of the pregnancy was normal in all cases. Preoperative antibiotic prophylaxis with amoxicillin-clavulanic acid is safe and effective in laparoscopic management of an ovarian cysts during pregnancy.

P-8

Mini-invasive surgery for correction of stress urinary incontinence, cystocele, rectocele

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The essence of our surgery is the blind conduction and fixation of anchor with secured non-absorbable thread without preliminary tunnel formation and skin inscision. The ends of the thread remains free, that permits to carry out different types of procedures: antistress surgeries, cystocele or/and rectocele correction. Also we have designed the guide for these surgeries. Mini-slings and ligature urethropexies were performed to correct urinary stress incontinence. If urinary stress incontinence was combined with cystocele we fixed a T-shape prolene flap to pubocervical fascia, in cases of isolated cystocele - tetragonal prolene flap. The frilled sutures were placed on the anterior wall of rectum during rectopexy in cases of rectocele. In all cases an elastic “hammock” with enough elasticity and rigidity was formed. Monitored results showed high efficacy and reliability all types of surgeries with observation period up to 4 years. 82% patients are continent. 3 cases of recurrent cystocele were noted and no rectocele recurrences. Thus, suggested mini-invasive surgery`s techniques have a high efficacy and reliability. The presence of different types of surgeries gives an opportunity to carry out combined pelvic floor reconstruction by new mini-invasive methods.

P-9

Suspected ovarian tumors in 16-row ct scanner angiography - preliminary report.

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Aim. We undertook this study to estimate the role and possibilities of 16-row CT scanner in differentiation of ovarian tumors based on morphological analysis, presence and type of pathological vessels.
Methods. The group consists of 19 women with uni or bilateral adnexal masses. The 16-row CT contains three phases (native, arterial, parenchymal). Tumor morphology was estimated using submilimeter slice collimation and considering the, structure number and derivation of tumor vessels in 3-D angioreconstruction
Results. In 9 women 16-row CT shown numerous pathological vessels, especially microaneurysm, inside the endofitic structures and septa. In these cases pathological reports noted: 8 ovarian cancers and one granulosa-cell tumor. In 5 patients suspected vascular changes were single and microscopic exams diagnosed 3 borderline tumors and 2 cases of fibrothecoma. In 5 patients without abnormal vascularization pathological reports shown 2 cystadenomas and 3 endometrioid cysts. In all cases, we reconstructed the main tumor arterial supply.
Conclusions. The resolution of 16-row CT angiography enables for high quality 3-D visualization of adnexal mass with intra and extra-tumor vessels which may strongly suggests malignancy.

P-10

Fact, Fallacies and Filshie Clips

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Female sterilisation is the most popular method of contraception worldwide when a woman has completed her family. In 1996, the CREST study was published in the US. Showing a higher than anticipated failure and ectopic pregnancy rate than had been expected. This study did not include the Filshie Clip, as it was not available in the US at that time. Present studies show that the Filshie Clip has a comparatively lower long-term failure and ectopic pregnancy rate. However, senior clinicians still quote the Crest Study figures for counselling purposes despite the Filshie Clip being used in their units. **Fact 1** Long-term failure rate of Crest Study is 36.5/1000 compared with 2.7/1000 for Filshie Clip. **Fact 2** Ectopic pregnancy rate in Crest Study is 1/3 of failures whereas the ectopic pregnancy rate of the Filshie Clip is 1 in 10,000 **Fact 3** The regret rate of the Crest Study is up to 20% 7 compared to just 5% with the Filshie Clip. **Fact 4** Mirena IUS has been quoted as having a failure rate equivalent to female sterilisation with Filshie Clips. The definitive study of the IUS compared to the Filshie Clip with intention to treat has not yet been undertaken. Pregnancies assosiated with patients who have had their IUS removed for pain, bleeding and side effects have not been included in the overall failure rate. The 5 year ectopic pregnancies with LNG-IUD-20 is reported to be 1 in 5000. **Conclusion:** In units where Filshie Clips are used for female sterilisation, Filshie Clip data should be used for counselling purposes not the Crest Study.

P-11

Bladder invasion in placenta praevia percreta: a multidisciplinary approach.

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A 29-year old woman develops a hypovolemic shock postpartum. A prompt hysterectomy is done with hemostatic intention. Pathology confirms a placenta praevia as cause of the hemorrhage. Postoperatively the patient stays anaemic despite multiple transfusions. An ultrasound shows a mass in the bladderwall. Because the patient has macroscopic haematuria a cystoscopy is performed. A giant extrinsic mass is visible; we conclude a placenta praevia a-percreta with bladder invasion. Conservative treatment with methotrexate is successful.
Placenta percreta with bladder invasion is a rare but potentially catastrophic complication of pregnancy. Adequate preoperative diagnosis and a multidisciplinary approach can reduce morbidity and mortality, both maternal and fetal.
The possibility of placenta percreta with bladder invasion should be considered in all pregnant women having hematuria, lower abdominal pain, lower urinary tract symptoms or painful ante- or prepartum hemorrhage with shock. Cystoscopy can be a useful diagnostic tool additional to the findings on ultrasound or magnetic resonance imaging. It also permits ureteral stenting which is helpful for intraoperative identification and can prevent ureteral injury.

P-12

Pregnancy outcome after laparoscopic myomectomy

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The aim of study is evaluate the efficacy of laparoscopic myomectomy for infertile patient who had uterine fibroids.Material and methods A total 22 laparoscopic myomectomies was performed in infertile women. The technical procedure was similar in all cases (laparoscopic nucleation of myoma and endoscopic suture by reabsorb material). All fibroids were morcelleted by electrical device morcelator.Results The average age of patients was 33 (26-39) of which 86% consulted for primary sterility and 18% of the women also presented endometriosis. The average surgery time was 93.25±39.55 minutes (40-180). The characteristics of enucleated fibroids were as follows. All fibroids were of intramural location. Diameter on major fibroid was 3.97±2.00cm (1.5-10). Number of fibroid enucleated 1.64±0.79 (1-3). Only two cases the scission arrived into uterine cavity. The hematocrit diminished after surgery 4.5 pointsPregnancy rate was 68.2% (15 patients). In 5 cases the pregnancy was through ART Pregnancy outcome was as follows: 9 cases vaginal term delivery; 5 cases by caesarean section doe to obstetric conditions and 1 pregnancy was miscarriaged at first trimester.ConclusionsThe nucleation of uterine fibroid with laparoscopic myomectomy is effective for infertile women. Pregnancy outcomes were overall vaginal delivery. The results show the efficiency of laparoscopic myomectomies to obtain safe pregnancies.

P-13

Laparoscopy in uterine malformations

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The aim of this study is to assess the role of laparoscopy in the management of uterine malformations. **Material and Methods.** Between 2001 and 2003 three patients with ecographic and clinical diagnosis of uterine malformation underwent laparoscopy to make an accurate determination of malformations or to manage the abnormality. **Results.** Three laparoscopic procedures were performed in these patients. One patient with Rokitansky-Kuster-Hauser (MRKH) syndrome underwent creation of a neovagina using modified Vecchieti's operation by laparoscopy. In one patient with didelphic uterus and hypo plastic non-cavitated uterus an laparoscopic hemihysterectomy of the atrophic hemi uterus was performed. The last patient was a 16 year old patient with didelphic bicollis uterus and blind hemivagina with hematocolpos, hematosalpinx and endometriosic ovarian cyst. Ipsilateral hemicolpectomy and ovarian cystectomy was performed. No complications were observed during the operative procedure,six months after surgery menstrual period was normal in the two patients with didelphic uterus. The neovagina was functional in the patient with MRKH syndrome. **Conclusion.** Laparoscopy is not only useful for diagnosis of uterine malformations, but can also be valuable for any treatment required for this type of malformation.

P-14

Successful laparoscopic treatment of unruptured cornual pregnancy: A case report

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Background: Cornual pregnancy is an uncommon localization of ectopic pregnancy with high potential risk of complications. Laparoscopic surgery is generally considered contraindicated as it may be associated with profound bleeding.
Case: A case of unruptured cornual pregnancy was treated with laparoscopic surgery. A 38-year-old woman with no previous surgical procedures, presented in our hospital with abdominal pain and spotting 8 weeks after her last menstrual period. Ultrasound showed a right adnexal mass with an embryo of 7 mm that presented positive heart beating. Serum beta-hCG was 3088 mU/ml. Laparoscopic findings established a diagnosis of right cornual pregnancy. The products of gestation were removed laparoscopically, after infiltration of 30cc of diluted adrenalin (1:500.000). The bleeding area of myometrium was first coagulated using bipolar forceps and then sealed with three laparoscopic intracorporeal knots that included cornual myometrium. Gynecare Interceed barrier was left in the surgical area. Patient was discharged 48 hours later without further complications.
Conclusion: With the increasing experience in the laparoscopic technique, cornual pregnancy can be managed safely and successfully by laparoscopic surgery.

P-15

Laparoscopic management of adnexal masses

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Objective & Methods: The frequency and effectiveness of laparoscopy in 191 women with adnexal masses during the year 2003. Frozen sections were routinely performed, but patients with pre-op findings suggestive of malignancy underwent laparotomy.
Results: The mean age was 35.1 years (20-70). The diameter of the masses ranged from 2-15 cm and mean operative time was 54 min (29-110). The left side was involved in 93, the right in 71 and both in 27 women. Histology was as follows: endometriosis (156), dermoid cyst (5), unruptured follicle (4), ovarian fibroma (1), haemorrhagic luteal cyst (7), serous cystadenoma (6), hydrosalpingx (6), para-ovarian cyst (4). Frozen section of 2 endometriotic cysts revealed epithelial cancer and an immediate laparotomy was performed. In six (6) women laparoscopy was converted to laparotomy because of operative difficulties, mainly adhesions. Complete cystectomy and removal in a bag was performed in 63.2% of cases, but the cyst ruptured prior to removal in the rest. There were no operative complications.
Conclusions: Careful preoperative evaluation identifies women who can safely undergo laparoscopy, but unsuspected ovarian carcinoma can be found rarely. This shows the importance of complete removal of the cyst and that patients should be properly informed and consented for immediate staging laparotomy.

P-16

Diagnosis of endometrial cancer by hysteroscopy does not increase the risk for microscopic extrauterine spread in early stage disease.

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Objective: To determine whether women with endometrial cancer have a higher incidence of microscopic extrauterine spread in early stage disease when diagnosed by hysteroscopy compared to being diagnosed by dilatation and curettage (D&C) or endometrial biopsy (Pipelle). **Methods:** We retrospectively reviewed the medical records of 110 patients who had undergone surgical staging for endometrial cancer from January 1997 to December 2003. They all had a preoperative histological diagnosis of endometrial carcinoma without evidence of extrauterine disease. Diagnosis was made by hysteroscopy in 64 patients (58.2%), by D&C in 17 (15.5%) and by endometrial biopsy using a Pipelle device in 29 (26.3%). Microscopic intraperitoneal disease and positive peritoneal cytology were considered the primary endpoints of this analysis. **Results:** The study cohort was divided into three groups according to diagnostic procedure: D&C, Pipelle and hysteroscopy. The women did not differ in the parameters of age, grade and stage of tumor or vascular space involvement. Peritoneal cytology was positive in 3/110 (2.7%) patients. The presence of positive peritoneal cytology was not associated with hysteroscopy as diagnostic procedure(p=1).Conclusions: Diagnosis of endometrial cancer by hysteroscopy does not increase the risk of microscopic intraperitoneal spread compared to diagnosis by D&C or Pipelle.

P-17

Assessment of hysteroscopic polypectomy of small endometrial polyps

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Objective: Endometrial polyp is a common finding in patients with dysfunctional uterine bleeding. Although the common practice is to remove these polyps, the effectiveness of this procedure, especially in small polyps (<1 cm), is not well defined. We assessed the clinical effectiveness of excision of small endometrial polyp in patients with dysfunctional uterine bleeding.
Methods: From January 2002 to December 2003, 145 patients with menometrorrhagia and small endometrial polyp underwent hysteroscopic polypectomy. Telephone questionnaire follow-up was performed to assess effectiveness and patient satisfaction 6-9 months after the procedure. Complication rate was assessed by questionnaire and by examination of medical records.
Results: A total of 134 patients (92.4%) were available for follow-up. After the procedure, 85.1% reported significant improvement in vaginal bleeding complaints and 64.9% reported returning to regular menses. Only seven patients were hospitalized for more than one day. Satisfaction with the procedure was expressed by 91.8% of patients. There were only five minor complications.
Conclusions: Even small endometrial polyps (<1 cm) may be a major cause of dysfunctional uterine bleeding. Excision of these polyps by hysteroscopic polypectomy is an effective, safe and well-tolerated procedure.

P-18

Persistent fever following surgical unwinding of ovarian torsion - Report of two cases

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Objective: We have adopted a conservative approach in ovarian torsion and prefer to treat these patients with laparoscopic unwinding of the ischemic ovary. In the majority of cases the ischemic signs of the ovary are reversed. We present here two cases with persistent fever resulting from ischemia.
Case 1: A 26-year-old woman was admitted to our department complaining of abdominal pain. On laparoscopy the ovary appeared ischemic. After the operation her fever persisted despite antibiotic treatment. Extensive investigation, including diagnostic laparoscopy, revealed no cause of fever. The fever resolved only after a third laparoscopy and adnexectomy.
Case 2: A 19-year-old woman underwent laparoscopic unwinding of a twisted ischemic ovary. On the first post-operative day her fever was elevated. A broad-spectrum antibiotic was administered. On the sixth postoperative day the fever resolved and the patient was released. On follow-up ultrasound three months later the left ovary could not be visualized.
Conclusions: Persistent fever following conservative laparoscopy for ovarian torsion may occur, caused by necrotic tissue. Laparoscopic unwinding of the twisted ovary remains the preferred treatment, but awareness of the risk of this complication is essential.

P-19

Bilateral heterotopic pregnancy after ovulation induction

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Objective: Heterotopic pregnancy is a rare complication of spontaneous pregnancies with increased frequency in pregnancies achieved with assisted reproduction techniques. We present a case of bilateral heterotopic pregnancy after ovulation induction.
Case report: A 26-year-old woman with unexplained primary infertility was treated with Gonal-F. At 6 weeks LMP she presented with severe abdominal pain. Ultrasound investigation revealed an intrauterine gestational sac with a 6-week embryonic pole with visible heartbeat. The patient was found on physical examination to be pale with quickened pulse. Laparoscopy revealed excessive blood and clots in the abdomen, burst right Fallopian tube with gestational tissue, and swollen left Fallopian tube. Bilateral salpingostomy was performed with removal of gestational tissue from both tubes. The pathologic examination revealed trophoblast tissue from both Fallopian tubes.
Conclusion: Bilateral heterotopic pregnancy is a rare event. Laboratory tests and imaging techniques are not sufficiently sensitive for diagnosis. Clinicians must maintain a high level of suspicion for this complication in high-risk women.

P-20

Use of Pelvic Organ Prolapse Quantification system in Korean Population Women.

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Objective: The aim of our study is to apply the POP-Q staging system to women seen for gynecologic care to generate normative data for Korean population women.
Methods: The study population considered of 486 women aged to 19 to 72 years old who seen for annual Papanicolau test and pelvic examination. Pregnant or patients within 6 weeks postpartum were not recruited. All pelvic examinations were performed by a single examiner with the subject placed in the dorsal lithotomy position by means of pelvic examination chair.
Results: The subjects had a mean parity of 2.1(range 0-6) and a mean body mass index of 22.2 kg/m2(15.7-30.9). Mean scores that described the position of the cervix, the position of the posterior fornix and the total vaginal length were as follows: C: -5.0 D: -6.6 and tvl: 7.0 cm. The overall distribution of POP-Q system stages were as follows: stage 0, 66.5%; stage 1, 21.8%; stage 2, 11.5%; and stage 3, 0.2%. No subjects examined had stage 4 prolapse. Conclusion: Vaginal size of Korean population women differs from that of Western population women. We are hopeful that the normative data presented in this study may provide a useful reference for physician as they evaluate prolapse an attempt to restore normal pelvic anatomy.

P-21

Evalution of Laprovaginal Hysterectomy using The Biswas Uterovaginal Elevator (BUVE) and associated technique.

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Objective: To evaluate and compare the surgical outcome for laprovaginal hysterectomy using the BUVE and associated technique at Blacktown District Hospital (BDH) to outcome reported by other units.

Design and method: Retrospective review of case history notes, manual extraction of data and literature review. Data from two hundred and twenty four consecutive laprovaginal hysterectomies using the BUVE and associated technique at BDH was compared with other techniques of laprovaginal hysterectomy reported by other units. Variables analysed included patient demographics, intraopeative complications including ureteric injury, cystotomy, bowel damage or conversion to open procedure and postoperative complications including febrile morbidity, non-autologous blood transfusion and hospital readmission

Result: The above indicators compared favourably to the ones reported by well recogised endoscopic units using other methods of laprovaginal hysterectomy. Conclusion: Laprovaginal hysterectomy using the BUVE and associated technique compares favourably to other recognised techniques for both complication rate, and mean operating time.

P-22

Posterior colpotomy and endobag - vaginal extraction of laparoscopic specimen minimalizing spreading of potentialy malignant cells into abdominal cavity.

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OBJECTIVE: To report our detailed technigue and clinical outcomes of transvaginal extraction of the laparoscopical specimen in endobag by posterior colpotomy. DESIGN AND METHODS: Charts of 18 patients who uderwent laparoscopical unilateral oophorectomy or salpingo-oophorectomy for ovarian mass followed by vaginal extraction of the laparoscopical specimen placed into endobag were rewieved retrospectively. Median tumor size was 6,5 cm(4-9). In all cases was posterior colpotomy performed vaginaly. RESULTS: Median operative time from incision of vagina to the complete suture of the colpotomy was 15,5 min (6-21). No intra- and postoperative complications occured. No spillage or loss of solid parts of the surgical specimen occured. Blood loss was minimal. Intraoperative frozen section was performed in 10 cases. One granulosacell tumor occured and extention of operative procedure for unilateral pelvic and paraaortic lymphadenectomy and excision of laparoscopic ports performed by laparotomy. CONCLUSION: Removal of the laparoscopical specimen placed into endobag by posterior colpotomy is efficacious and safe method minimalizing spreading of potentialy malignant cells into abdominal cavity. Intraoperative frozen section allows extention of surgery in the same anesthesia.

P-23

Do we still need to do hysteroscopy as an inpatient procedure for abnormal uterine bleeding?

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Audits on inpatient (81 cases) and outpatient (94 cases) hysteroscopy were carried out. The indications, success rate and abnormality detection rates were compared. The need for doing hysteroscopy on an inpatient basis was assessed and the role of ultrasound prior to hysteroscopy reviewed. The success rates were comparable. The abnormality detection rate was slightly higher for out-patient hysteroscopy (35%) compared to in-patient hysteroscopy (28.6%). The disadvantages with outpatient hysteroscopy were 1) 3% inappropriate referrals 2) 22% needing subsequent inpatient hysteroscopy due to a) unsuccessful outpatient hysteroscopy b) unsuitability for outpatient hysteroscopy and c) intrauterine polyps requiring subsequent inpatient hysteroscopy for removal. The use of USG as a screening test to detect intrauterine polyps was therefore assessed. All patients did not have an ultrasound therefore numbers assessed were small. The detection rate was higher in postmenopausal compared with premenopausal patients. The disadvantages with inpatient hysteroscopy are 1) wastage of precious theatre time, resources and costs 2) increased anaesthetic complications and delayed recovery. In conclusion, inpatient hysteroscopy still has a role as intrauterine polyps are difficult to remove at outpatient hysteroscopy. Until USG is more sensitive in detecting intrauterine polyps, inpatient hysteroscopy subsequent to initial outpatient hysteroscopy is inevitable.

P-24

Endometriosis of the Diaphragm and Lung. Diagnosis and Treatment aspects - a case report

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A 39 year old lady with known pelvic endometriosis presented with new symptoms of cyclical right shoulder tip pain, right basal chest pain and shortness of breath. Chest X-ray showed tiny nodular shadowing in the right upper lobe. CT scan showed similar nodular opacities in the periphery of the mid zones of the lungs. These radiological changes are not typical of pulmonary endometriosis but may represent an atypical presentation in the absence of other pulmonary pathology. A diagnostic laparoscopy revealed severe pelvic endometriosis. Inferior surface of the diaphragm showed endometriotic nodules and scarring on the right hemi-diaphragm in two large areas. She will receive 6 cycles of GnRH-analogue therapy followed by laparotomy involving pelvic clearance and ablation/resection of the diaphragmatic disease. This case demonstrates that pulmonary symptoms may have origin in the abdomen. One should inspect the diaphragm in all cases of pelvic endometriosis at the time of laparoscopy. Management of extrapelvic disease poses a problem. Diaphragmatic endometriosis may be resected laparoscopically using CO_2 laser or at laparotomy by full thickness resection of diaphragm. Recent evidence suggests that the latter is more effective. Pulmonary endometriosis requires long term medical suppression. In extreme cases surgical excision of the affected lobe may be required. Treatment should be individualised.

P-25

A Review of our experience in Laparoscopic treatment of adnexal masses in the last 30 months.

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Objetive: To evaluate the morbility of 80 patients that had been diagnosed by the ultrasound diagnosis of benign adnexal mass and treated by laparoscopy at our hospital.
Design and methods: This is a descriptive and retrospective study of 80 patients, from January 2002 to June 2004. We analyze different factors. We carry out a statistical study using SPSS computer analysis.
Results: The mean age was 35.81 (17-70), 17.5%(14) of which were in a menopausal state. The patients were 0 parity in 52.5% of the cases (42). One patient was pregnant at the time the laparoscopy surgery was carried out. The average size of the mass, was 61.91 mm (1-145). There were 5 cases (4%) of bilateral mass, the number of cases that requiring laparotomy were 9 (11.3%), the rate of intracomplication was 17,55%(14), and the post surgical complication rate was 12,5%(10); the average convalescence post surgery days was 2.33(0-9); there was one case that required blood transfusion(1,25%), the type of surgery most practised was Quistectomy(60%), there was only one bordeline tumor(1,25%).
Conclusions: The laparoscopy is a safe surgical method for the management of benign adnexal mass. It allows a conservative treatment in most of the cases with a small number of complications.

P-26

Ovarian transposition in premenopausal patients with cervical cancer receiving radiation therapy

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INTRODUCTION: Pelvic radiation (PR) in the treatment of cervical cancer can cause iatrogenic early menopause in young women. Lateral ovarian transposition (LOT) before PR may preserve ovarian function in these patients.
OBJECTIVE: To assess the effectiveness of LOT before PR in premenopausal women with cervical cancer.
PATIENTS AND METHODS: Laparoscopic LOT was performed on 37 premenopausal women with cervical cancer. 28 patients stage Ib underwent Schauta radical hysterectomy and pelvic lymphadenectomy, and 8 patients stage IIa and 1 patient stage III underwent surgical staging with a pelvic and a retroperitoneal paraaortic lymphadenectomy. Menopausal symptoms and follicle-stimulating hormone levels were used to define ovarian function.
RESULTS: Only 1/18 (5.5%) patient who underwent LOT without postoperative PR had ovarian failure. In 9/19 (47%) patients who received postoperative PR therapy ovarian failure occurred. There were no surgical complications due to the LOT. No metastases were identified in the follow-up.
CONCLUSIONS: Laparoscopic LOT is a safe procedure that preserves ovarian function in 53% of patients undergoing PR for the treatment of cervical cancer.

P-27

Follow-up of the Essure® procedure: The accuracy of Ultrasound Control.

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Objective: **To compare the accuracy of transvaginal ultrasound and pelvic X-Ray for the location of Essure® intratubal devices at 3-months follow-up.**
Design & Methods: Retrospective observational study of 86 cases in which transvaginal ultrasound was carried out 3 months after insertion of intratubal devices. Results were later compared to pelvic X-Ray. Without previously knowing the result of the radiographic image, we have practiced transvaginal ultrasound measurements of uterus, endometrial thickness and location of devices. **Results:** Devices were easily identified in all women. In 81 (94.2%) cases satisfactory placement was assessed by X-Ray, 5 (5.8%) patients had a short or a long distance between devices (0 or >5 cm. respectively). Ultrasonography showed only one doubtful placement and HSG confirmed tubal obstruction.
Conclusion: Ultrasonography allows a easier control of devices, is performed in real time and can be practiced in the consulting room. The information about presence, location and relation to soft tissues is wider, more precise than X-Ray and provides a better knowledge of the exact position of devices in the pelvis. Finally, the number of HSG performed in case of doubt may decrease.

P-28

The effectivity of Versapoint™ in ambulatory hysteroscopy

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Objetives: To analized the efectivity of Versapoint® bipolar system for the treatment of endouterine benign pathology in consulting setting
Design & Methods: Retrospective analysis of 4808 hysteroscopies perform in consulting room since the beginning of 2000 until December 2003.
Results: During this period, 305 polyps out of 1270 were treated with Versapoint, 29 myomas out of 314 and 12 septum out of 54. The size of polyps treated with Versapoint ranged between 3-60 mm, and the myomas were always less than 25 mm. Very small polyps or myomas were treated only with mechanics instruments (scissors or forceps), and very large ones were treated in the surgery room. When the Septum seemed very thick by histeroscopy, it was also resected in surgery room (12 cases), and in 17 no treatment was applied because it has no medical indication. All the septum treated were control two months later with a diagnostic histeroscopy, and all cases had a cavity of normal size. There were no major complications during Versapoint® use.
Conclusions: Versapoint bipolar system is very effective in the treatment of polyps, myomas and septum in consulting setting and so avoiding hospital admission and the risks of general anesthesia.

P-29

Ultrasound assessment in Essure™ placement control

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Objetives: To assess if ultrasound can substitute radiologic studies in Essure® placement control.
Design & Methods: Prospective and blind study with 129 women with Essure® device inserted. Abdominal and vaginal sonography are realized without any preparation. Both devices are tried to be identified and the uterine portion is measured. All patients had already have a radiologic control and 4 out of 129 patients only have unilateral insertion, and the sonographer did not know this.
Results: In all women the ecography could identify the correct or uncorrect placement of the devices. In 119 cases of 129 patients an abdominal ultrasound was enough to assesss a correct placement. There was a high concordance between hysteroscopic intrauterine portion and sonography uterine portion. Sonography could avoid 15 of 22 HSG
Conclusions: (1) In all cases sonography could avoid a simple X-ray. (2) Sonography could avoid 68% of HSG. (3) There is a high concordance between hysteroscopic intrauterine portion and sonography uterine portion. (4) In 86% of cases abdominal sonography without preparation was enough to assess the placement, and only 14% needed a complementary vaginal approach.

P-30

Essure™ system in córdoba (spain): a social revolution

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Objetives: To analyze the social demand on tubal esterilization and how a modern unit try to absorb it.
Design & Methods: Epidemiological description
Results: In October 2002 we demonstrated that tubal sterilization could be easily achieved with Essure™ system with 10 women. Since then, the number of women who demand the method progressively increased until march 2004, when more than 400 women were waiting for this method. This high demand was due to the high rate of satisfaction in women already treated (99%), and because of the easy accessibility for women to the method.
In 2003 was done 208 cases(17,3 per month). In 2004 was done 433 cases in 6 month (36 per month). Total amount of 651cases. The failure rate was only 2.16%, in eight cases due to bilateral tubal obstruction and in 5 because of unilateral. During the same period of time analyzed the number of vasectomy deceased with a parallel tendency,
Conclusions: Essure™ system has the meaning of a social revolution in our sanitary area because of it low failure rate, the high satisfaction in women and the easy accessibility due to our quick response to the highly demand.

P-31

Post-Partum Female Sterilization

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Post partum female sterilzation is not very popular in the UK, due to the perceived higher failure rate over interval procedures. The use of the Filshie Clip for post partum female sterilization has mixed results. However, to date there has been no publications relating to the laparoscopic approach. This study includes patients between 01/01/90 and 31/12/94. Eighty four paitents have been sterilized. The technique was performed between day 1-7 post partum. General anesthetic was employed. The patients' remained supine on the operating table. Verres needle was inserted through the umbilicus, unless previous abdominal surgery had occurred, the Verres needle was then inserted just below the costal margin on the left side. The abdomen was insufflated to a pressure of 20mm of Hg. A 10 mm laparoscope was inserted subumbilically. The laparoscope was inserted in the mid clavicular line 4-5 cm below the costal margin, where previous surgery had occurred. The second puncture was placed in the right or the left iliac fossa depending on the circumstances. The tubes are easily identified and clipped 2-3 cm from the cornu. If difficulty in visualizing the tubes occurred a trendelenberg position was adopted. All patients had the procedure completed. There were no problems encountered with blood vessels or bowel. There were 3 minor infections at the umbilical site. No failures occurred. Conclusion: Post partum laparoscopic female sterilization with the Filshie Clip appears to be a simple and safe procedure when conducted with an experienced surgeon.

P-32

Early repair of the bladder and ureter injury following gynecological laparoscopic surgery: a case report.

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We evaluated 2 cases of bladder and ureteral lesions recognized soon after gynaecological laparoscopy. A vesicovaginal fistula developed postoperatively in a 52-year-old woman after laparoscopic hysterectomy. The complication was diagnosed in 6 days and repaired laparoscopically at 11-th day after primary surgery. A 39-year-old woman got partial left ureteral damage after electrocoagulation and dissection of deep infiltrative endometriosis at the ovarian fossa. The complication was recognized on the 6-th day of postoperative period. After unsuccessful attempts at stenting, a laparoscopic reconstruction of the distal ureter was performed on the 10 day of postoperative period by ureteroureteral anastomosis. Patients recovered fully. Delayed recognition of low urinary tract injuries is associated with serious complications, which management still remains controversial in regard to the timing of repair and the type of approach. Contrary to the traditional doctrine of delayed intervention our hospital attempted to operate as soon as possible after the diagnosis was made. Results suggest that there is no disadvantage in early repair. We advocate that recently acquired laparoscopic urinary tract injury may be repaired definitively soon after diagnosis. However, surgical timing and route of repair are best tailored to an individual patient.

P-33

Laparoscopic management of ovarian cysts in pregnancy: a case report

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The impact of persistent ovarian cysts in pregnancy is uptoday extimated around 0.15% with, however, an increasing trend in comparison with the past years. The ovarian cyst management is currently strongly debated. During October 2003, we examined a 36 years old patient at the 8th week, with a ultrasound diagnosis of ovarian cyst (51×65 mm) with mainly liquid consistency, without septations and escrescences. Tumoral markers dosage (CEA, CA 125 e CA19.9) was negative. Due to the persistency of the cyst's diameter increase, we decided to remove it by laparoscopy at the 17th week of amenorrhea. We produced the access according to the "open" technique by the introduction of optical probe at the umbilical district and two secondary paths. The cyst was aspirated and then we proceeded to strepping of the cyst's capsula, and finally to a prudent electro-cauterization of the cyst region with bipolar coagulator. The hystological examination revealed a benign cystadenoma and the patient was discharged in two days. No complications were reported during and after the operation.
In 1963 Munndell wrote that treatment of an ovarian cyst in pregnancy was indicated; after 40 years this recommendation is still applicable with, however, the use of new medical technology with laparoscopy only by expert surgeon.

P-35

Hysteroscopic removal of residual trophoblastic tissue

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Retrospectively we evaluated the efficacy of hysteroscopic removal of residual trophoblastic tissue in terms of menstrual disorders, occurrence of postoperative adhesions and postoperative fertility. The procedure was performed in 15 patients for prolonged postpartum (n=12) or postabortion (n=3) bleeding. Placental remnants were detected by transvaginal ultrasound: 10 polyps were round/oval with clear borders, 5 were coral shaped without clear borders. The average size of the remnants was 2.2 cm. The resectoscope loop was used for blunt removal and electricity for removal of extensive remnants. Pitressin was used in all cases with coral shaped remnants that were prone to extensive bleeding. In 2 patients uterine septum and in 1 intrauterine adhesions were resected as well. Of the 15 patients, 3 refused second-look hysteroscopy, 3 became pregnant before second-look hysteroscopy was planned: 2 pregnancies ended in a normal delivery, 1 was ectopic; the latter patient had already had two ectopic pregnancies. In 9 patients second-look hysteroscopy revealed normal uterine cavity and endometrium. None of the patients reported menstrual disorders. There were no surgical complications. Hysteroscopic removal of residual trophoblastic tissue is safe and efficient, and must be seriously considered as an alternative to classical curettage, particularly in patients requiring repeat curettage.

H-36

The Risk of Ectopic Pregnancy in Lactating Women.

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OBJECTIVE: Our goal in this preliminary study was to find the prevalence of lactation in women with Ectopic Pregnancy (EP) and evaluate it's weight among other known risk factors affecting the occurrence of EP. METHODS: In a retrospective cohort study we reviewed the files of 100 consecutive women hospitalized with a diagnosis of EP and evaluated among them the prevalence of different risk factors. RESULTS: Among women with EP, 12 (12%) were breast-feeding women, 46 (46%) had no known risk factor for EP, 42 (42%) had a previous pelvic operation (21 cesarean section and 21 other operation), 14 (14%) were smokers, 12 (12%) had infertility treatment (6 ovulation induction, 5 I.V.F treatments and one I.U.I), 12 (12%) had a previous EP, 6 (6%) were oral contraceptives users, 4 (4%) had an IUD, 5 (5%) had a previous episode of PID. Among Breast-feeding women 8 (66%) had no other known risk factor. CONCLUSIONS: The prevalence of breast-feeding among women with EP seems to be higher than expected and matched that of other known risk factors such as infertility treatments or prior EP. It seems that breast-feeding in it self may be associated with EP. Further research into EP should focus on breast-feeding.

P-38

Pain and localization of disease in the endometriosis primary treated with laparoscopic methods

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The pain appearance in endometriosis is usually connected with cytokines produced by active focuses of endometriosis or influence of adhesions in chronic stage of disease. Our research was carried out in patients subjected to operation with laparoscopic method due to diagnostics of chronic pain of abdomen or sterility. After operation they were treated with analoges of GnRH or danasol for a 6 months. We evaluated the intensity and localization of endometric lesions in the early grades of disease (AFS stage I, II) with taking into consideration appearance of pain at 58 patients aged 20-40. Among 73% patients, who suffered from pain, we significantly more often observed active focuses of endometriosis localized on sacro-uterine and broad ligaments of the uterus and on the peritoneal surface of Douglas cavity. In over 40% of patients there were slight adhesions. We noticed the maintenance of pain in 42% of women, in spite of primary operation, connected with cauterization of endometric focuses, removing the adhesions and 6 months of pharmacotherapy. In this group adhesions maintained more often (77%) than in group without pain (33%). However lesions on sacro-uterine ligaments and in Douglas cavity maintained similarly often in both groups. Ascertainment of adhesions during primary diagnosing of early grades of endometriosis might suggest significant difficulties in obtaining satisfied improvement of pain occurrence in women-patients.

P-39

Pre-operative endometrial thinning before hysteroscopic surgery: which is the best dose of danazol?

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We compared two different doses of danazol as preoperative thinning agent before endometrial ablation. Between Jan. 1990 and Dec. 2003 126 patients aged 35-55 underwent hysterscopic endometrial ablation for disfunctional uterine bleeding. We administrated danazol preoperatively for 25.3 days on average (21-28). I group (74 patients) received 200 mg/day, II group (52 patients) received 400 mg/day. The period of treatment was the same in the two groups [I group 25.4 days (21-28) II group 25.1days (21-28)]. Hysteroscopic treatment was performed by Storz rotary resectoscope. All patients received spinal anaestesia. After the operation we performed blood test on each patient to evaluate serum aminopherase. Surgical outcome was excellent without intraoperative and postoperative complications. There weren't any differences between the two groups in operating time [I group 22.3 min (11-35) II group 23.5 min (12-34)], bleeding and serum level of aminopherase [AST: I group 32.3 (28-39) II group 35.8 (30-42)]; [ALT: I group 27.3 (20-35) II group 28.5 (22-34)]. The cost of the treatment was 39.40 euros for I group and 50.14 euros for the IIgroup. The efficacy and the safety were the same in the two groups, but the treatment of the first group was cheaper.

P-40

Early feeding and mobilization allow early discharge

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We evaluated the time of discharge after early feeding and mobilization. Between Jan. 2000 and Dec. 2003 116 patients aged 20-45 underwent laparoscopic treatment for benign adnexal pathology (45 ovarian cysts, 9 ectopic pregnancies, 10 tubal abscesses and 52 endometriotic cysts). Every patient received general anaesthesia. During the day before the treatment we administrated to every patient 75 ml of senna followed by 2 litres of water and 50 drops of dimethicone every 4 hours for 6 times. The operating time was on average 45 min. (25-195). 6 hours after the end of the surgical treatment we removed catheter and we administrated semolina or tea and rusks. Then they stood up and they had a little walk around the bed. Just one patient underwent traditional surgery for haematoperitoneum. 23(19,8%) patients needed additional analgesia (ketorolac 10 mg). 5(4,3%) patients presented nausea, but there wasn't any episode of vomiting. 103(88,8%) patients were discharged after 24 hours, 12(10,3%) patients went home after 48 hours for subscapular pain and/or pelvic pain. None of them presented anaemia, fever, hypouresis and ileus. Early feeding and mobilzation reduce pain caused by meteorism and allow early discharge.

P-41

Spinal anaesthesia for hysteroscopic surgery

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We evaluated the safety and the efficacy of spinal anaesthesia for hysteroscopic surgery. Between Jan. 1990 and Dec. 2004 542 patients aged 24-55 underwent operative hysteroscopic treatment for different indications (polyps, leiomyomas, endometrial ablation, uterine septa). All patients received a spinal block performed with a whitacre (27 G needle with bupivacaine 0.5% hyperbaric solution 10mg at L_2-L_3 or L_3-L_4 level. Only few cases (10%) required an additional conscious sedation with midazolam 2-5 mg. Hysteroscopic treatment was performed by Storz rotary resectoscope. The outcome was excellent without any fluid overload or other intraoperative and postoperative complications. The operating time was never longer than 60 minutes and the absorption of distention fluid was never larger than 700 ml. Spinal anaesthesia for operative hysteroscopic treatment presents a relevant advantage: the vasodilatation induced by blocking the simpatic nervous system. This is of critical importance considering the absorption of distention fluid.

P-45

Congenital Cervical Agenesis

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Congenital absence of cervix has been described in a limited number of cases. The real incidence is unknown.
A total of 10 patients admitted to SSK Ankara Maternity Hospital Department of Infertility, a tertiary level reference center, from January 1998 to May 2004 were reported. Surgical reconstruction of internal genitalia, restoration of normal menses and maintenance of a patent genital tract are challenging problems for the gynecologist. After preoperative pelvic examination, the diagnosis was possible by transabdominal and tranvaginal/transperineal ultrasonographic examination, hormonal evaluation and MRI. In six cases cervical and vaginal agenesis were complete. However two patients had cervical hypopasia and partial vaginal agenesis in conjunction with spontaneous mestruation. Two patients had a didelphic uterus one with a complete cervical agenesis, the other partially. Management options evolved as experience with this very rare condition increased. Laparoscopic and open surgical techniques, alone or in combination were discussed.

P-46

Uterine myoma with mixomatous change : a case report

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Case: a 45-year-old-woman with methrorragia since five months. Past obstetrical history was noted. A previous ultrasound scan showed a myoma in the uterine fundus of 3,8 cm of maximum diameters. Free edge myometrium was 5,9 mm.
Outpatient hysteroscopy showed a myoma who occupied the entire uterine cavity and the measure was estimate to be about 4 cm. She was advised to perform a myoma resection after GnRH-agonist treatment (3/12). She performed the resection, and during the procedure initially the tumour was well defined, but afterwards a mucinous matter came out from myoma. Histopatology showed a typical myoma with mixomatous change. Three months after surgery an ultrasound was done and the uterus was normal. A month after scan office hysteroscopy showed a normal uterine cavity with a small medial fundus synechia. At present patient is ongoing well.
Conclusion: Patient's prognosis was not poor because no mitosis were observed, the only nuclear abnormalities being dyschromia and dysmetria. These findings were not sufficient to make diagnosis of malignant. Hysteroscopy provided complete recovery.

P-47

Cesarean scar and abnormal uterine bleeding

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Objective: To correlate abnormal uterine bleeding (AUB) and previous delivery.
Materials and methods: 307 pre-menopausal women complaining of AUB. Past obstetrical hystory was noted. Among them 118 were nulliparous (control group); 141 had one or more spontaneous vaginal delivery (SVD); 40 had one or more low segment caesarean section (LSCS) and 8 had one or more LCSC with at least a SVD. All women performed hysteroscopy in order to exclude intrauterine pathology. All women with previous LSCS revealed the presence of a pouch, on the anterior uterine.
Results: Hysteroscopic findings did not show in LSCS group any intrauterine pathology in 66%, polyps or myomas in 23% and cervical polyps in 10%. In nulliparous women the incidence of intrauterine pathology was 48%, while the incidence of pathology in women with previous SVD was 39%.
Conclusion: higher percentage of normal cavity in women with previous LSCS seems to suggest the scar as the cause of bleeding.

P-48

The management of anatomical and functional uterine disorders in infertilized womens

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Aim of the study: To improve anatomical and functional uterine abnormalities.
Methods: Laser surgery, laser-ozone therapy, immunohystochemical evaluation of receptors, electro-physiological control of myometrium and sphinctores.
Objective: 112 women aged 24-42 with infertility lasting from 2 to 12 years. 95 patients had undergone IVF (2-8 attempts).
Results: Pregnancy rate 63%. Correlation in sphinctors activity, myometrium and hormone menstrual cycle, increasing and direct distribusion of estrogen and progesterone receptors levels, immunologic changes in cervical mucose plug.

P-49

Anatomical and functional abnormalities in uterus in infertilized females.

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Aim of the study: To evaluate the influence of uterine curretage and inflammation on anatomical and functional abnormalities in infertilized women.
Methods: microbiological, physical and chemical, immunological, endoscopical, electro-physiological.
Objective: 112 women aged 24-42 with infertility lasting from 2 to 12 years. 95 patients had undergone IVF (2-8 attempts).
Results: 69 (61%) patients had stenosis and adhesions of cervical canal, 47 (42%) had anatomical lesions of internal oss, 56 (50%) women had contractive dysfunction of myometrium. 74 (66%) - dysfunction of external oss and tubal oss.
Besides 37 (33%) patients had intrauterine adhesions, polyps, fibroids and septi.
Conclusion: Inflammation and curettage of endocervix and endometrium lead to anatomical and functional disorderes of endocervix and endo-myometrium and sphincters.
Endocervical mucous plug destroing causes immunological abnormalities.

V-1

Total Laparoscopic hysterectomy with LIGASURE

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We have performed total laparoscopic hysterectomy with LIGASURE. Laparoscopic LIGASURE of 5 mm diameter is an innovative vessel sealing and dividing instrument. It's a bipolar radiofrequency coagulator that allows a fast sealer of vessels and follow cut of tissues. The termal diffusion and damage of near tissues is minimal and there isn't carbonisation of coagulated structures. This is very useful when we coagulate the uterine arteries without to cause ureteral damages. Surgical times are the same of classical total laparoscopic hysterectomy (TLH), but much faster, because LIGASURE allows a progressive action of dissection, coagulation and cut of tissues with reduction of operative times. We have used LIGASURE for round ligaments, infundibolo-pelvic ligaments, uterine arteries, bladder dissection, parametrium, utero-sacral ligaments, while the incision of vagina is performed with monopolar needle. We have utilized the manipulator of Valkev for uterine-vaginal manipulation. The disadvantage of LIGASURE is represented by high cost of disposable instruments but lower than Stapler's suture (ENDOGIA) or ultrasound coagulators and safer than classic bipolar coagulators.

V-2

The Fertiloscopy: a new endoscopic technique in day surgery in infertile patients

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We have performed fertiloscopy according to Watrelot's technique that consists of transvaginal hydrolaparoscopy, dye test, salpingoscopy, hysteroscopy and in expert endoscopists, microsalpingoscopy. The fertiloscopy is made under local or loco-regional anaesthesia and all the patients are discharged from the hospital at the same day. The includion criterias were: patients with history of infertility at least of two years, satisfactory ovulation, cervical mucus and spermiogram normal, hysterosalpingography considered normal or subnormal (bilateral dye test acceptable), mono or bilateral tubaric stenosis (tubal spasm or organic stenosis?). The exclusion criterias were: backwards uterus, suspition of Douglas endometriosis, suspition of severe pelvic adhesions. The limits of this technique are: impossibility of vision of anterior uterine wall but this area is seldom included in infertility except for anterior fibroids easely diagnosticated with vaginal scan and gynaecological examination; fertiloscopy doesn't diagnosticate the endometriosis of utero-vesical pouch but this one is rare in absence of other areas of endometriosis. The fertiloscopy represents today a diagnostic and operative technique very interesting that allows in day surgery the complete management of tubal-ovaric peritoneal infertility.

V-3

218 Laparoscopic subtotal hysterectomies. Methods and results.

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The video presentation shows the so-called tripolar cutting forceps used in all parts of the procedure except in morcellation. We have recorded among other things indications, previous caesarean sections, operation time, uterin weight, peroperativ complications, posoperativ period, the results of pathological examination of the uterus, days lost through illness. Two major complications (damage to the ureter). Conversion to open operation in 8 cases. The length of hospital stay and convalescence are short. Overall the results are promising and economical.

V-4

Demonstration of a technique of laprovaginal hysterectomy using the Biswas Uterovaginal Elevator (BUVE).

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Objective: To demonstrate the surgical technique of laprovaginal hysterectomy using the BUVE.
Design and method: Video presentation of the surgical technique of laprovaginal hysterectomy using the BUVE.
Result: The surgical technique of laprovaginal hysterectomy using the BUVE offers the advantage of ease of use making it surgeon friendly. The significantly reduced complication rate also makes it cost effective and attractive to health providers and health economists.
Conclusion: Laprovaginal hysterectomy using the BUVE and associated technique compares favourably to other recognised techniques for both complication rate and mean operating time. Subsequently, it is user friendly and cost effective technique.

V-5

Breast duct micro-Endoscopy

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Breast tissue is affected by a plethora of clinical conditions with benign inflammation at one end of spectrum and cancer at other end. Pre operative investigations such as ultrasonography or mammography seldom explain etiology of the nipple discharge. None of the imaging modalities available for the diagnosis of early breast cancer today give us direct access to the ductal epithelium, which is in fact the point of origin of all breast carcinomas. Breast duct micro-endoscopy (BDME) is a new technique, which in the case of nipple discharge has the advantage of being able to detect lesions deep within the ductal system. For women at high risk BDME has the potential to detect breast malignancy at pre-invasive stage (DCIS and ADH) and therefore to possibly prevent some cases of invasive breast cancer. The ductal system is evaluated under direct vision. Micro-endoscopes as small as 0.5 mm external diameter are available. The new generation of scopes also have a working channel through which instruments like a micro-brush can be inserted. The micro-brush now provides opportunity for first time to collect samples from endoluminal lesions. The technology has opened up a whole new world of endoscopic biopsy and even surgery.
This video describes the anatomy of breast ducts, the instruments used, the operative procedure, indications for use and the future prospects of this procedure.

V-7

LAVH in the treatment of endometrial cancer

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Objective: presentation of the technique of LAVH in endometrial cancer. Pelvic lymphadenectomy is performed by transperitoneal approach.The peritoneum overlying the iliac vessels is incised and iliac artery and vein are identified. The lymh nodes in the iliac and obturator area are dissected and removed through the reduction tube.The obturator nerve and vessels are identified and the preparation is continued to the pelvic wall. The round ligament is coagulated and cut.The vesico-uterine peritoneal recessus is incised with sharp scissors or monopolar electrode and the vesical wall is partially separated from the uterus. The infundibulopelvic ligaments are isolated,coagulated and cut.The vaginal part of the operation begin with circumferential incision of vaginal wall using the monopolar electrode. The posterior cul-de-sac is incised with scissors and the sacral ligaments are coagulated or ligated and cut. Ligasure is used to assure hemostasis in vaginal part of operation. The vesico vaginal septum is dissected and the bladder is separated from the vaginal wall. The uterine vessels are coagulated with Ligasure standard. The uterus with adnexa is removed through the vagina and vaginal wall is sutured.Conclusion: LAVH and laparoscpic lymphadenectomy are the effective technique in patients with good vaginal access.Ligasure standard may be useful in vaginal part of operation to assure hemostasis.