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ABSTRACTS

Abstracts of Oral, Poster and Video Presentations British Society for Gynaecological Endoscopy Silver Jubilee Meeting 'Preparing for a Golden Era' Central Hall Westminster, London 4th & 5th June 2015

Video Presentations

FCV1- Interstitial Pregnancy: A Novel Technique Using Misoprostol, Modified Dillon's Method and Operative Laparoscopy to Minimise Blood Loss

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Introduction:
Interstitial pregnancy is rare with an incidence of 1:2500-5000 live births. It has a mortality rate that is 7 times higher compared to tubal pregnancies and is associated with excessive blood loss.
Case Report:
A 26 year old lady presented at 7 weeks of pregnancy with vaginal spotting. She previously had a 10 week miscarriage. A trans-vaginal ultrasound revealed a right sided interstitial pregnancy based on the Timor Tritsch et al criteria. There was a 3.5 x 4.4cm highly vascular cornual mass containing a gestation sac and yolk sac. Her β-HCG level was 85,874 IU/L. She was offered emergency laparoscopic surgery. Per rectal Misoprostol 400mcg was administered at induction of anaesthesia to increase myometrial contractility and vasoconstrict the arcuate and spiral arteries. An Endoloop was placed around the base of the pregnancy to occlude the Sampson artery. A modified Dillon's method where 20IU of Pitressin diluted with 200ml of normal saline was used to minimise cardiovascular compromise. Dillon first described dilution with 100ml of normal saline in 1958. 60mls was injected beneath the Endoloop with blanching effect. The Harmonic Ace Scalpel was used to perform a cornuostomy and right salpingectomy. Closure was in two continuous layers using Stratafix Spiral Poly Dioxanone (PDO) sutures. PerClot (hydrophilic polysaccharide) was applied for haemostasis and Hyalobarrier gel to reduce adhesion formation. The intra-operative blood loss was 300ml.
Conclusion:
This is a novel combination of modified Dillon's method with medical and surgical techniques to treat an interstitial pregnancy with minimal blood loss.

FCV2- En-bloc resection of "the butterfly area" for deep infiltrating endometriosis

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Complete removal of deep infiltrating endometriosis is crucial to the resolution of symptoms in women suffering with severe endometriosis. We describe the technique of en-bloc resection of "the butterfly area" for deep infiltrating endometriosis. Removal of this area en-bloc ensures complete removal of the disease. Resection of "the butterfly area" includes peritoneum along with the endometriotic deposits covering bilateral pelvic sidewalls, bilateral uterosacral complexes along with the rectovaginal nodule.

Steps include:

1. Thorough pre-operative work up including transvaginal scan by a gynaecologist to diagnose recto-vaginal disease. IVP and MRI are performed if deemed necessary. Ureteric stenting is performed if extensive disease is located adjacent to ureters.
2. A pelvic survey is performed followed by adhesiolysis. Uterine and ovarian suspension is performed to optimise access.
3. Bilateral ureterolysis and subsequently resection of lateral pelvic sidewalls is performed.
4. A rectal manipulator is inserted to clearly define the rectal margins.
5. This is followed by hypogastric nerve sparing resection of deep infiltrating endometriosis and all the peritoneum over bilateral pararectal spaces.
6. Resection of peritoneum over the rectovaginal septum and resection of any nodules in this region is performed.
7. At the end of the procedure, bowel integrity test is performed using air and methylene blue.

FCV3- Fluorescent Indocyanine Sentinel Node Dissection for Endometrial Cancer

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We will present the first indocyanide green sentinel node dissection in the UK for endometrial cancer as part of the Royal Marsden Hospital FRIE NDS study. Flourescent Robotic Indocyanine Endoscopic Node Dissection Survey (FRIENDS).

FCV4- The 8 Steps of Excising Deep Infiltrating Endometriosis

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GB is a 26 year-old nulliparous woman who presented with subfertility, dysmenorrheoa, cyclical rectal bleeding, dyspareunia and intermittent pelvic pain. A first stage laparoscopy performed by a fertility specialist revealed stage IV endometriosis. She was subsequently discharged on GnRH analogues and referred to us. Pelvic MRI confirmed rectovaginal endometriosis involving the full anterior rectal wall thickness. A sigmoidoscopy revealed petechial patches in the anterior rectum suggestive of endometriosis. She understood that clearance of her endometriosis may improve her chances of conception and her pain. She was also informed that she will require bowel resection with the possibility of a colostomy. Bowel preparation was prescribed preoperatively.
Laparoscopy revealed severe endometriosis in both uterosacral ligaments, a large rectovaginal nodule eroding through the posterior fornix and a stenosing lesion in the mid rectum, affecting 2/3 of the bowel thickness. After ureteric stenting, we resected all the rectovaginal endometriosis and repaired the vagina with interrupted Monocryl sutures. The rectum was then mobilised and the colorectal team using a 33mm EEA gun, under antibiotic cover, completed an anterior resection. The ovaries were normal and the tubes patent. She had an uncomplicated recovery and was discharged home 72 hours later.
The footage of her operation has been edited using a variety of techniques, to depict the 8 basic steps of excising Deep Infiltrating Endometriosis.

FCV5- 12-week size Ectopic Pregnancy in a non-communicating uterine horn - VIDEO

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Case Presentation
A 20 year old female presented to A&E with abdominal pain and chest pain. A CTPA was organised for investigation of the chest pain. The patient was subsequently found to have a positive pregnancy test, however, she consented to proceed with the investigation. This was negative for pulmonary embolus but demonstrated fluid around the spleen. HCG was 45,000 with progesterone of 41. A TV USS consequently showed a 12 week size live ectopic pregnancy with free fluid.
Laparoscopy revealed a unicornuate uterus on the left hand side with a non-communicating rudimentary horn on the right with an ectopic pregnancy within the horn and fallopian tube, attached onto the pelvic side wall. There was blood filling the pelvis. Right ureterolysis was performed and the pelvic side wall dissected to allow removal of the ectopic pregnancy and the uterine horn.
Discussion
Ectopic pregnancy is a common presentation with 1-2% of pregnancies affected. However, ectopic pregnancy within rudimentary uterine horn occurs in only 1:76,000 to 1:140,000[i]. These pregnancies have increased and there should be a high index of suspicion as the consequences are high with maternal mortality. Rapid management by laparoscopy is crucial to reduce the morbidity and mortality.
[i] Iran J Reprod Med. 2015 Jan;13(1):49-52. Unruptured rudimentary horn pregnancy presenting with acute haemoperitoneum with combined intrauterine pregnancy: A case report. Lallar M, Nandal R, Sharma D.

FCV6- Single sheet laparoscopic ventral mesh rectopexy and hysteropexy for complete uterine prolapse and full thickness rectal prolapse

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Aim: To evaluate the efficacy and safety of single sheet laparoscopic ventral mesh rectopexy and hysteropexy for full thickness rectal prolapse and complete uterine prolapse. A video of the procedure will be presented.
Methods: Over a 5 year period, 12 women presented with full thickness rectal prolapse and complete uterine prolapse to at least 3 cam below the introitus. The procedure involved dissection of the rectovaginal septum to the level of the pelvic floor and attaching a single sheet mesh to the ventral surface of the rectum and then to the posterior aspect of the cervix. Women were evaluated pre and post operatively with the Prolapse Quality of Life Questionnaire, and Pelvic Organ Prolapse Quantification System and Patient global Impression of improvement.
Results: All procedures were successfully completed with no complications. Complete anatomical cure of rectal prolapse was achieved in all cases and all patients reported feeling either much better or very much better on PGII. Obstructive defecation symptoms particularly incomplete evacuation persisted in 2 cases despite anatomical cure of rectal prolapse
Conclusion: Single sheet ventral mesh rectopexy can be combined with hysteropexy in women with multiple compartments prolapse of the pelvic floor.

FCV7- Ultrasonic excision of endometriosis: what you see is what you burn, or perhaps not?

Shaheen Khazali[1], Christina Stylianou[1*], Alexandros Derpapas[1]
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High-frequency ultrasonic technology has less lateral thermal spread than most electrosurgery modalities. These devices, however, ultimately work by generating heat and therefore can easily cause burns to adjacent organs.
In this video, we present a case of a 42-year old woman who sustained a superficial burn to the small bowel by a Harmonic scalpel during a total laparoscopic hysterectomy. In an otherwise straightforward procedure, a small bowel burn occurred when the surgeon accidentally touched a loop of ileum with the non-active blade of the ultrasonic device, seconds after ligation of the uterine artery. A 2-3 cm longitudinal white-coloured thermal line was immediately recognised on the bowel serosa, but no further damage was revealed after careful inspection of the proximal and distal bowel. Colorectal surgeon's opinion was sought who advised conservative management without over sewing the burn line. The patient was closely observed as outpatient and was asked to attend for further blood test a few days later. She made an uneventful recovery with no sequelae.
Thermal bowel injury is the most serious type of bowel injury as it is less likely to be recognised intraoperatively and peritonitis may occur up to 14 days later. Ultrasonic devices can get very hot. The jaws of these instruments, therefore, should be kept in view at all time and the device should not be used to manipulate or grasp tissue when recently activated. Intraoperative recognition of such injuries can be life saving.

FCV8- Video case presentation of laparoscopic bilateral salpingectomy for chronic pain developed after Essure hysteroscopic sterilization showing migration of the wires via the serosa of both tubes

Claire Stewart[1*], George Botros[1]
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Title: Laparoscopic Bilateral Salpingectomy for Chronic Pelvic Pain Developed After Essure Hysteroscopic Sterilization Showing Migration of the Wires Via the Serosa of Both Tubes.
A 34years old lady developed chronic pelvic pain after outpatient Essure hysteroscopic sterilization for almost a year. The hysteroscopic procedure was uneventful. Three months check by HSG confirmed wires in place and bilateral tubal blockage. Since the procedure the patient developed chronic persistent bilateral iliac fossa pain for more than 9 months. A diagnostic laparoscopy showed migration of the middle part of both wires outside the tubes. The proximal ends of the wires were seen in the uterine ostia and the distal ends of the wires in the tubal lumen. The patient agreed to proceed with removal of both tubes and the wires. The following edited video shows the above described findings and the technique of removal of the tubes and the wires by laparoscopic approach.

FCV9- Transvaginal ultrasound diagnosis and laparoscopic excision of bladder endometriosis

Tom Holland[1*], Ertan Saridogan[1], Alfred Cutner[1]
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Bladder endometriosis affects up to 4% of patients with endometriosis. The symptoms include cyclic cystitis with menstruation and occasionally cyclic haematuria. The ultrasound features of thickening of the bladder wall, adjacent and adherent to the uterus are typical and facilitate an accurate diagnosis in the majority of cases.
In this video we show a case of bladder endometriosis with a videos of the pre-operative ultrasound findings, the cystoscopy findings, bilateral insertion of ureteric Pollock catheters, laparoscopic excision of the diseased area and laparoscopic interrupted suturing of the bladder at University College London Hospital.

FCV10-The role of illuminated ureteric stents in laparoscopic excision of severe endometriosis

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Introduction: The incidence of ureteric injury is reported to be between 0.08% and 8% depending on the complexity of laparoscopic surgery. Laparoscopic excision of infiltrating endometriosis can be challenging and poses an increased risk for ureteric injury. We have used illuminated stents for 17 years for selected cases to prevent ureteric injury.
Objective: To describe our experience from the use of illuminated ureteric stents Rocket Uriglow^{R} during laparoscopic treatment of severe endometriosis.
Methods: Out of the 45 cases submitted to the BSGE database we identified 26 cases of treatment of severe endometriosis from January 2014 to January 2015 where Uriglow^{R} ureteric stents were used intra-operatively. We reviewed the intra-operative findings and the intra-operative and post-operative complication rates.
Results: The insertion of illuminated ureteric stents takes less than 10 min and it can reduce the need and extend of ureteric dissection and the associated morbidity. We had no ureteric injuries during this case series. All our patients experienced transient post-operative haematuria that did not affect their recovery. Two patients developed urinary tract infection at 2 and 4 weeks post-operatively (7.7%). It is difficult assess whether the infections were secondary to the insertion of the stents or the cystoscopy.
Discussion: The insertion of illuminated ureteric stents is a safe procedure that ensures easy identification of the ureters and prevents ureteric injury. It is a skill that it is easily learnt and should be considered in complex laparoscopic pelvic surgery where ureterolysis and pelvic side wall dissection proves to be difficult or risky.

Oral Presentations

FC1- Haemorrhage reduction techniques used in myomectomy surgery: a survey of UK practice

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Uterine myomas (fibroids) are benign tumours of the uterus but in 20-50% of women the symptoms they cause warrant treatment. Myomectomy surgery carries with it significant risks including haemorrhage, need for blood transfusion and emergency hysterectomy. These negatively impact on the aims of the surgery, patient's fertility wishes and length of hospital stay.
A Cochrane review, in 2011, reviewed 'Interventions to reduce haemorrhage during myomectomy for fibroids'. Unfortunately, this review was unable to conclude that any one approach to reducing blood loss was superior. Currently, there is significant heterogeneity in the techniques and approaches used by gynaecological surgeons.
An on-line survey was designed to collect information on surgical experience, techniques used to minimise blood loss and preferences. In particular, we gathered data on the use of Vasopressin and frequency of complications. This survey was distributed to members of the British Society of Gynaecological Endoscopy (BSGE) as a representative group of UK gynaecologists.
We will present data from 108 clinicians, which were initially presented at the RCOG World Congress in Brisbane. This will include a breakdown of the techniques used and the preferences expressed by users. In particular we will present the data related to the use of intra-operative Vasopressin-the average number of units, the use of diluent, the administration technique and the complications experienced.
Although limited by recall bias, this survey gives a good guide to UK practice. It helps to highlight the potential advrse reactions clinicians should be aware of when using Vasopressin to reduce intra-operative blood loss.

FC2- Taking it one step further to tariffs: Better Care, Better Value

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Introduction
Hysteroscopy is the gold standard in the investigation of abnormal uterine bleeding. Outpatient hysteroscopy (OPH) is a safe and effective technique. Despite this, most hysteroscopies are still performed under general anaesthesia (GA). It is pertinent that clinicians demonstrate an understanding of healthcare rationalization. The concept of Best Practice Tariffs (BPTs), introduced by the Department of Health (DoH) in April 2010, aims to promote clinical excellence and cost effectiveness. The DoH anticipates 80% of women to receive OPH.
Methods
A prospective audit of the OPH service was carried out in order to assess current practice, success rates and overall patient satisfaction. Information on national tariffs and local costs were also sought to identify opportunities for improvement.
Results
Indication for OPH included postmenopausal bleeding, abnormal uterine bleeding and polypectomy. The overall success rate of the procedure was 98%. 23% of patients required hysteroscopy under GA. The average pain score during the procedure was 4.3 out of10 (4.2/10 for vaginoscopy, 5.3/10 with traditional hysteroscopy technique). Overall patient satisfaction score was 9.7 out of 10. A significant correlation between intra-

procedural pain and satisfaction exists (P<0.05). BPT for OPH is higher (£472) than those under GA (£268).
Conclusion
Vaginoscopic OPH is a well-tolerated procedure with minimal pain and high levels of patient satisfaction. Such positive results should encourage migration to OPH. We need to explore additional strategies for minimising discomfort. Given the financial constraints of the NHS, the leverage of financial incentives combined with clinical quality will spur an expansion of OPH service.

FC3- Development of a Core Outcome Set for Heavy Menstrual Bleeding

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Core outcome sets (COS) are an agreed, standardised set of trial outcomes that clinicians and patients consider critical or important in the management of a condition. COS are disease specific and should form the minimum data sets to be collected and reported in clinical trials of that condition. The aim of COS is to prevent selective reporting, improve data synthesis.
Heavy menstrual bleeding (HMB) is an important health issue which affects 1 in 5 women of reproductive age. Currently there is no COS for HMB. Developing a COS for HMB will ensure that future trials report useful outcomes that benefit women, clinicians and healthcare service providers alike.
COS development will follow methodology recommended by COMET (Core Outcome Measures in effectiveness Trials) and will include all relevant stakeholders. Reported outcomes are identified by literature searches, and patient workshops are held to identify outcomes that are most important to them. The outcomes are combined into a long list and a three round Delphi survey is conducted asking participants (patients and their families, clinicians, nurses) to rate the importance of each outcome to move towards consensus. A consensus meeting is held to finalise the COS. Dissemination of the HMB COS will be via publication in CROWN (Core Outcomes in Women's Health) initiative journals.
We will present results of the first stages of development of a COS for HMB and discuss the heterogeneity that exists across studies. We will also promote our HMB Delphi survey and encourage interested clinicians to register their interest.

FC4- Outpatient Endometrial Ablation: The Benefits and Advantages of Conscious Sedation

Cecilia McKee[1*], Camilla Lyon-Dean[1], David Pachter[1], Will Wight[1], Tony Chalhoub[1]
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Background:
Outpatient endometrial ablation has revolutionized the management of heavy menstrual bleeding. The optimal treatment, currently advocated to be under local anaesthetic (LA) has significant limitations, which could be overcome with the use of Conscious Sedation (CS).
Aim:
To demonstrate the benefits of CS over LA for outpatient endometrial ablation, based on observational data from a large teaching hospital where Endometrial ablation under CS is standard.
Method:
LA endometrial ablation was initially introduced in this unit, but due to high patient pain scores, CS was later introduced. Data was collected prospectively (at time of procedure and before discharge) from 2007 until 2013, but retrospectively analysed. The anaesthetic protocol involves Midazolam and a variable infusion of Remifentanil
Results:
66 patients underwent Endometrial Ablation under LA (Group A), and 122 under CS (Group B). Using a Likert-type 5 point scale, (0=no pain, 1=mild pain, 2=acceptable pain, 3= very painful, 4=worst pain) 50% of patients in group B reported scores of 0, with 94% reporting acceptable pain, or less. In Group A, the majority reported scores of 3 or 4. In Group A, 14% had procedure abandoned, with no abandoned procedures in group B, and no complications related to sedation. Patient satisfaction post CS was 87%.
Conclusion:
Our data demonstrate that CS provides a safe and effective means to carry out almost all endometrial ablations in the outpatient setting. This improves patient experience, and in the longer term, with the consideration of nurse-led sedation, would prove more cost effective

FC5- Treatment decision-making and support needs in heterosexual couples living with endometriosis

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Endometriosis impacts upon a range of domains including intimate relationships. However, previous research has focused on the woman at the expense of her partner who may also be negatively affected by the condition and its treatment.
Couples were interviewed to provide in-depth data on living with endometriosis, either as patient or partner. This paper focuses on decision-making regarding management, and couples' information and support needs.
Twenty-two heterosexual couples, together for at least 12 months, and where the woman had laparoscopically-diagnosed endometriosis, were recruited via NHS clinics, support groups and snowball sampling. Separate, in-depth, face-to-face interviews (n=44) were conducted and transcribed verbatim. Data were analysed thematically and dyadically.
Treatment decisions had implications for both partners. The majority of couples reported discussing surgical and medical options together, with men being described as 'largely supportive'. However, whilst women reflected on living with and managing the condition in the longer term, men reported a desire for a cure and, for some partners, hysterectomy was perceived as a way to "fix" endometriosis.
Healthcare professionals need to consider the role of partners in treatment decision-making and be aware that within the couple unit patients and partners may have differing views about how endometriosis should be treated.
Signposting to support groups and relevant information, along with couple-focused information that highlights the effect of endometriosis on relationships, would be welcomed by patients and their partners. In addition, men highlighted the need for advice on how best to support their partner and cope with living with endometriosis themselves.

FC6- New Laparoscopic Peritoneal Pull-Through Vaginoplasty Technique

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Background: Many reconstructive surgical procedures have been described for vaginal agenesis. Almost all of them are surgically challenging, multi-staged, time consuming or leave permanent scars on abdomen or skin retrieval sites.
Aim: A new simple technique using laparoscopic peritoneal pull-through in creation of neo vagina has been described.
Material Methods: Total of forty five patients with congenital absence of vagina (MRKH syndrome) were treated with laparoscopic peritoneal pull through technique between 2003 till 2014. The author has described 3

different techniques using, thin peritoneal graft, thick peritoneal graft with substratum, and combined use of peritoneum with amnion grafts (in patients with pelvic kidney peritoneum retrieval is difficult)
Results: This technique has given excellent results over a period of one to seven years of follow-up. Using the principle of Mullerionosis the peritoneum is transformed in normal multi-layer vaginal epithelium. The peritoneal lining changes to stratified squamous epithelium resembling normal vagina and having acidic Ph. Vaginal biopsies were done at various stages of follow-up, from one month to one year.
Conclusion: In conclusion the new laparoscopic peritoneal pull-through vaginoplasty offers a relatively easy surgical procedure with excellent results on long term follow up. This procedure is practically devoid of morbidity associated with other techniques. Peritoneal lining undergoes metaplasia and transforms itself in to stratified squamous epithelium resembling normal vagina. This transformation has been documented in 9 patients.
As the ovary became accessible per vaginum 3 patients underwent ovum retrieval and pregnancy using surrogate mother making this a fertility enhancing procedure.

FC7-Laparoscopic hysterectomy. Does minimal access surgery alone maximise recovery?

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Introduction
Laparoscopic surgery has been credited with multiple benefits when compared to open surgery. One of them is a more rapid return to work and normal activities. The Department for Work and Pensions is seeking to develop evidence based guidance on periods of incapacity for work following common procedures. Current recommendation for return to full activity after laparoscopic and laparoscopic assisted vaginal hysterectomy is 3 weeks. 7 weeks for abdominal hysterectomy. We wanted to find out if that is realistic.
Methods
Patients who underwent laparoscopic hysterectomy for benign condition at Whipps Cross University Hospital between 2011 and 2013 were contacted by phone. Data was collected through a questionnaire designed and validated by the authors and later analysed.
Results
33 patients were included in the study and 21 (63%) of those worked, and of those, 18 (54%) of them took 8 weeks or more to return to work. 16 (48%) described her job intensity as moderate and 4 as heavy. Overall there was no relationship to the intensity of work, the number of hours worked or job satisfaction. 12 patients did not work, 11 (33%) of them took 8 weeks or more to return to normal activities.
Conclusion
Recovery from hysterectomy can be longer than expected. Laparoscopic surgery alone without good postoperative support may not be enough. The authors feel that Enhanced Recovery programs could help maximise the benefits of laparoscopic surgery.

FC8- Validation of a new Endometriosis Surgical Scoring system (Visual Numeric Endometriosis Scoring System-VNESS) using Videotaped Laparoscopic Procedures

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Background: VNESS has been developed to facilitate clear and easy communication of intraoperative findings for endometriosis. It consists of 8 numbers, each corresponding to an area of the pelvis starting clockwise from the left adnexa, Each compartment is given a score of 0-4 depending on the severity of the disease.
Objective: This project aims to examine the inter-rater and intra-rater validity of VNESS. This is phase 2 of a bigger project. Phase 1 was development, conceptualisation and consultation, which has concluded.
Materials and methods: 63 edited videos of endometriosis laparoscopic procedures were scored by three scorers, twice using VNESS, producing 378 sets of VNESS scores. Theese were then examined for inter-rater and intra-rater agreement.
Results: VNESS showed excellent intra-rater and inter-rater agreements. The mean percentage agreement in all the 8 areas for the two rounds of scoring was between 83.9% and 87.7%. For all the scorers the mean percentage agreement in all the 8 areas for the two rounds of scoring was 85.7% (range 73.2% - 95.8%). The level of perfect agreement (the percentage of the 63 video pairs on which all scorers scored exactly the same) was strong (>90%) for adnexa, pelvic sidewall and uterovesical fold, but noticeably weaker (< 75%) for both Uterosacral Ligaments and Pouch of Douglas.
Conclusion: VNESS is a simple, intuitive and reliable system for scoring of endometriosis and may have application for audit and research. Some adjustments may be needed to optimise the system to make it more descriptive and discriminative.

FC9- Enhanced recovery pathway for laparoscopic hysterectomy, a model to follow in major gynaecological surgery. Study of a pilot protocol to assess feasibility and demonstarte measurable outcomes

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Introduction
Creating Enhanced recovery pathway in gynaecology will apply the best evidence to stream up practice in a very standardised steps which can be audited. The enhanced recovery will require a central investment in a team that will involve many facets of the care.
Methods
This is a study of the effectiveness of applying a pilot protocol in laparoscopic hysterectomy. In 20 cases the elements of the pathway were well applied and these included preoperative patient education and pre assessment. All cases were admitted on the same day of the operation and were given gabapentin 300mg BD and laxatives BD for 7 days postoperatively. Local anaesthetic was used at the wounds at the start of the procedure and some was left in the pelvis at the end.
Results
There was reluctance to give preoperative energy drinks in all of the 20 cases. Only 4/20 cases reported mild pain in recovery and the rest reported no pain. 2/20 were discharged on the same day and the rest were discharged on next day with no pain. 18/20 cases had no catheter on discharge from theatre and no one needed recatheterisation. 4/20 had postoperative nausea the rest were given oral fluids in recovery. There was 2/20 cases with minor complications on follow up.
Conclusion
Enhanced recovery requires leadership and change of culture on the part of surgeons, anaesthetists, and nursing staff. It is not only important to do the procedure with best of technical skills but to ensure early return to function with maximum patient satisfaction. Laparoscopic hysterectomy offers a model of care to apply to other gynaecologic procedures.

FC10- Taking the red pill or the blue pill - How to turbo charge our laparoscopic skills using neurofeedback

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Objectives
Since the EWTD was fully implemented in 2009, it has become apparent that the experiential model of learning has to change dramatically, if the

NHS is to continue to produce safe and well-trained surgeons in this changing environment.
Attention, concentration, focus and emotional balance are key to peak performance in all areas, including laparoscopic surgery. Neurofeedback is direct quantification and training of brain function, it is brainwave biofeedback, allowing you to learn how to maintain brainwave activity associated with optimal brain function.
We present the application and promising results of brainwave training on enhanced performance of basic laparoscopic skills, consolidated by neuroplasticity.
Material
Our proposed system utilises a state-of-the-art Bluetooth EEG biosensor headset, the NeuroSky MindSet. A high-end laptop is required for data capture and data processing. Sophisticated software is used to detect the full range of brainwave activity and analyse this data using complex algorithms.
Method
6 trainee doctors with varying levels of laparoscopic experience were randomized into either receiving neurofeedback therapy prior to basic laparoscopic skills training or just receiving skills training. The test group took part in a daily session of brainwave training, for three days. The completion of simple tasks on a box trainer was timed on day four, to compare, if the application of neurofeedback sessions improved performance in the test group.
Results
The test group showed up to 12% improvement in performance of simple, directed tasks.
Conclusion
Neurofeedback therapy can play a vital role in achieving peak performance levels during laparoscopic skills training.

FC11- Virtual Reality Laparoscopic Simulator: Face Validity of Essential Gynaecological Procedures

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Introduction
Simulation-based skills training in laparoscopic surgery leads to enhanced quality of performance, reduced errors, shorter operative time and superior patient safety profile. The aim of this study was to determine trainers and trainees assessment of face validity of the Simbionix LAP MentorTM III in three essential gynaecological procedures.
Methods
27 gynaecologists (5 Consultants, 3 Senior Registrars, 13 Registrars, 6 Senior House Officers) were orientated to the training modules. Subsequently, at their convenience they performed bilateral tubal ligation, bilateral salpingo-oopherectomy and right salpingectomy, for tubal ectopic pregnancy. Following completion, a ten-point Likert-scale questionnaire was completed evaluating each task based on appearance of instruments and pelvic tissue, manoeuvring and function of instruments, response to tissue manipulation, depth perception, ergonomics of the simulator and overall utility as a training tool.
Results
The median Likert-scale scores for the appearance of instruments, hand-eye coordination and utility as a training device tasks were scored 9. The instrument manoeuvring & function of instruments, appearance of tissue and response to manipulation, depth perception, bimanual handing and simulator's ergonomics were rated a median score of 8.
Conclusion
Instrumentation, tissue depiction and response to manipulation appear to have a high face validity. The Simbionix LAP MentorTM III was regarded as a valid training tool. In our next steps, construct and predictive validity assessments will enable construction of a proficiency based curriculum. We believe the simulation based training can translate to clinical benefit in gynaecology.

FC12- Laparoscopic Myomectomy versus Open Myomectomy- A meta analysis of Randomised Controlled Trials

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Background: Leiomyomata are the commonest benign tumours of the female genital tract and are associated with a number of symptoms including difficulty to conceive. Leiomyomata can be surgically removed with preservation of the uterus in women with symtomatic fibroids who wish to retain their fertility. The procedure, myomectomy can be achieved via laparotomy, laparoscopically or hysteroscopically depending on the site, size and type of myoma. There is paucity of data with regards to which approach is associated with the best outcomes in terms of subsequent pregnancies.
Method: A systematic review to assess pregnancy rates after laparoscopic myomectomy compared with pregnancy rates follwing open myomectomy is presented. The following data bases were searched: PubMed Central, Medline, BioMed Central, CINAHL (EBSCO), ScienceDirect, Cochrane library ,Google search in general and Google scholarly. Studies which met the inclusion criteria were selected and analysed.
Results: Evidence from and Meta-analysis of the two randomised control trials which met the review criteria show no significant difference between laparoscopic and open myomectomy for large myomas with regards to subsequent fecundity, in women from the reproductive age group. The laparoscopic approach, if it is practicable, is associated with a number of patient advantages including less post operative pain, less fever, reduced blood loss, shorter length of hospital stay and faster return to normal activity.
Conclusions: The surgical approach to myomectomy does not appear to influence the subsequent pregnancy rate or outcomes. Interpretation is guarded because of the small number of studies eligible for analysis. Further large studies are required to validate the findings. The laparoscopic approach is, however, associated with a number of patient advantages including faster recovery and should be the method of choice.

FC13- Introduction of a novel approach to maintaining Pneumoperitoneum at Total Laparoscopic Hysterectomy (TLH)

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During TLH diathermy is used to circumferentially cut around the uterine manipulator. At this stage in the procedure CO2 can be lost.
We have developed a fluid filled "donut" which can be placed inside the vagina. This maintains pneumoperitoneum at the time of removing the uterus from the vagina. Once the specimen has been removed the "donut" can then seal the lower vagina while suturing takes place in order to avoid ongoing loss of CO2.

The following equipment is required:

- condom
- silastic foley catheter 14
- 60ml syringe
- suture material for tying (silk)
- Sterile water

1. The catheter is inserted inside the condom (3-4 cm of the catheter tip should be placed inside the condom)
2. Silk is used to tie a knot about 1cm from the end of the condom so it is fixed to the catheter

3. The tip of the condom should be then be placed alongside the above knot.
4. The tip of the condom is tied in place using the suture material forming a donut
5. The integrity of the donut is checked by filling it with 60ml of sterile water via the catheter.
6. Following insertion of the uterine manipulator the donut is threaded over the handle of the manipulator and pushed up the vagina close to the cup.
7. Prior to excising the cervix the donut is inflated with sterile water.
8. Following removal of the specimen the donut is replaced in the lower vagina to ensure ongoing pneumoperitoneum.

FC14- Opportunistic Laparoscopic Salpingectomy (OLS): An Opportunity for Training

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Introduction
OLS offers potential benefits to the patients including ovarian cancer risk reduction, reduced infective morbidity following hysterectomy and contraception. The concept of OLS offers an opportunity for training in an essential gynaecological procedure in an 'in vivo' setting. It would be vital to garner consensus prior to this significant step. This study explores the attitude of professionals toward OLS.
Methods
A survey was undertaken at five hospitals, recruiting trainees & consultants, theatre personnel and pathologists. The questionnaire permitted free text commenting.
Results
The response rate was 100% amongst 150 participants. Majority of the consultants (90%) and theatre personnel (100%) support the concept of OLS for training. Trainees reported, OLS would offer additional training benefit (Median score of 8/10). 46% of participants felt OLS for training may have adverse effect on the patients. 70% of participants felt further ethical exploration amongst patients would be warranted. 92% felt trainees should undertake prior simulation-based training. 91% of trainees had used a simulator with 37% having performed a simulated salpingectomy; the stage of training did not significantly influence the latter. 44% of theatre staff expressed OLS may impact on theatre work flow. 100% of consultants and pathologists recommend histological assessment of the surgical specimen.
Discussion
The clinic-pathological argument for OLS is compelling. OLS offers a unique training opportunity. The concept of OLS training could be enhanced through simulation based training. This would introduce the 'pre-trained' novice to the 'in vivo' training using OLS. This may resolve any ethical and safety concerns of OLS.

FC15- Laparoscopic Myomectomy for Large Myomas

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Introduction
Laparoscopic myomectomy has established itself as an alternative to open myomectomy. Its role in the setting of larger fibroids has been controversial due to technical challenges. We present a case series of laparoscopic resection of fibroids ≥8cm in our institution

Methods
This was a single-centre retrospective review of patients undergoing laparoscopic myomectomy for large fibroids (≥8cm) between September 2005 and December 2014. Outcomes included operative time, complications, blood loss and rate of conversion to laparotomy.
Results
One hundred and forty nine patients aged 25-64 years (median: 38) underwent laparoscopic surgery. The commonest symptoms were menorrhagia (29%) and pressure effects (28%). One hundred and fifty leiomyomas were removed, ranging between 8-20cm (median: 10cm) and weighing between 76-1600g (median: 450g). Operative time ranged from 55 to 300 minutes (median: 120 minutes) and 56 patients (38%) had a concurrent procedure. Blood loss was 20-2000mls (median: 150mls). Two patients underwent laparotomy for specimen retrieval. Five patients required blood transfusion. One patient had a pulmonary embolism. A single patient required laparoscopy for small bowel obstruction four weeks post surgery. Finally, one patient developed a collection and one an ileus. Both were managed conservatively.
Conclusion
This is the largest UK case series examining laparoscopic myomectomy for large myomas (≥8cm). Our findings demonstrate that in experienced hands a laparoscopic approach should not be limited by fibroid size per se.

FC16- A warm-up strategy is effective in reducing mental load during laparoscopic prophylactic bilateral salpingo-oophorectomy: A Randomised Controlled Trial

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Introduction
Laparoscopic prophylactic bilateral salpingo-oophorectomy (LapBSO) is performed as a risk reduction intervention for ovarian cancer. Pre-task warm-up is proven to enhance performance. This is the first trial to explore mental load during surgery.
Method
This is a cross-over randomised trial. Participants were stratified prior to computer generated allocation. Eighteen participants were first trained to proficiency bench. Training and assessments were completed on LAP Mentor virtual reality simulator. Each participant performed a 'control' LapBSO and a warm-up task followed by LapBSO. The warm-up task was 'circle cutting' which is FLS validated; this is time-limited to five minutes. During the LapBSO the participants were required to simultaneously perform a validated visuo-cognitive secondary task. After the LapBSO tasks, participants completed two validated questionnaires - NASA-TLX and subjective mental effort questionnaire (SMEQ).
Results
Warm-up intervention lead to significant reduction in SMEQ scores (P=0.02). In n four of the six dimensions of NASA-TLX, warm-up intervention resulted in significant improvement in workload measures [mental demand (P=0.04), temporal demand (P=0.015), performance (P=0.007) and frustration (P=0.003). The ratings approached statistical significance for physical demand (P=0.051) and effort (P=0.06).
The visuo-cognitive secondary task measure of mental load, revealed a significant reduction in mental load: the overall detection rate (P=0.003) and correct detection rates (P<0.05) were significantly higher in the interventional arm.
The correlation coefficient between mental load and SMEQ is significant for the control group (0.801) and interventional group (0.72); this strengthens our findings.
Conclusion
Pre-task warm-up is an effective technique in reducing mental load during LapBSO.

FC17- The effect of co-morbidity on the cost of laparoscopic surgery for endometrial cancer

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AIMS
To determine the effects of co-morbidities such as obesity, diabetes, hypertension and age on the in-patient costs of laparoscopic endometrial cancer (EC) surgery.
METHODS
Seventy seven patients with EC treated by laparoscopic surgery were assessed. Clinical data were obtained from the trusts electronic patient record (EPR). The costs of each in-patient episode were calculated independently by the trust's finance department and included the costs of staff, ward, theatres, drugs, intensive care, rehabilitation, pathology, imaging and blood products.
RESULTS
Diabetes was associated with an increased median cost of £2426.83 (P = 0.0385). Hypertension, age over 65, and a Body Mass Index (BMI) of over 30 were associated with median increased costs of £2070.66 (P = 0.0044), £1842.40 (P = 0.0084) and £1699.59 (P=0.0225) respectively. No statistical difference was demonstrated in median costs for women who had had a previous laparotomy.
CONCLUSION
Diabetes, obesity, hypertension and increased age are associated with a significant increased cost of surgery for EC. This should be reflected

FC18- Evolution in the surgical management of endometrial cancer (2007-2014) at the DELTA centre - Royal Derby Hospital

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Aims: Assess the changing management of endometrial cancer 2007-2014.
Methods: Patient records attained from cancer database. Data collected retrospectively from electronic records.
Results: 618 patients assessed. Age-mean=66 (28-92). Pre-operative investigations: endometrial thickness-mean=14.95mm (1-85mm), uterus AP diameter-mean=39.4mm for TLH (13-73mm), 44.6mm for TAH (20-96mm). Pre-op hysteroscopy 65.2% cases. Histology-88.1% endometrioid, serous 3.81%, carcinosarcoma 6.68%, other 1.41%. Management in 2008: TLH 15.9%, TAH 62.3%, LAVH 18.8%. In 2014: TLH 74.7%, TAH 22.1%, LAVH 1.1%. 40 laparoscopic cases combined with PLND. Operating time-mean: TLH 97.99 minutes(36-213), TAH 108.13 minutes(44-250), (P=0.0071). Estimated blood loss-mean:TLH 212ml, TAH 469ml (P<0.0001). Length of stay-mean: TLH 2 days, TAH 5 days (P<0.0001). Rate of conversion (TLH to TAH): 5.44%(overall) - declined 17.5% 2008 to 3.76% 2013-2014. Reasons for conversion: bleeding, adhesions, failed entry, uterus too big and other. Complication rate: TLH 8.9%, TAH 16%. Serious complications <1%. Rate of readmission: TLH 7.96% (commonly vault haematoma), TAH 6.54% (commonly wound dehiscence/infection).
Conclusions: In our large 8-year case series there has been a significant change in surgical management from open to laparoscopic surgery, resulting in significantly shorter operating times, hospital stays, and lower morbidity. TLH can increase bed capacity allowing more cases to be done. Increased morbidity with TAH may be due to the more complex cases over TLH (bigger uterus, higher stage disease). All centres should offer TLH as a gold standard for all hysterectomies. The DELTA centre has developed a Training Programme for consultants and senior trainees to facilitate a transition in practice in other centres.

FC19- 'Laparoscopic Hysterectomies in the obese: not so dangerous after all'

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Rising BMI is a growing problem, with the current UK average BMI for women being 27. Initially, morbid obesity was considered a contraindication to laparoscopic hysterectomy, however in advanced laparoscopic units it is now considered an indication for, rather than a contra-indication to the laparoscopic approach.
417 cases of laparoscopic hysterectomies were performed between 2010 and 2015 at the Countess of Chester Hospital. The average BMI was 29. Of these patients, 40 were identified as having a BMI of 40 and above. These patients had a higher incidence of co-morbidities such as diabetes, hypertension and mobility issues and were more likely to have a pre-cancerous or cancerous indication for surgery (50% vs 29%). BMI ranged from 40-68, operation times (knife to skin) were longer (122mins vs 103mins), with a longer length of hospital stay (43 hours vs 40 hours), higher rates of intra-op (2.5% vs 1.3%), post op (7.5% vs 2.6%) complications, and a higher rates of re-admissions (2.5% vs 2.1%). Major complications included a thermal bowel injury requiring laparoscopic minor bowel resection, and a patient on anti-coagulant therapy requiring a blood transfusion after re-admission following vaginal bleeding.
Laparoscopic hysterectomy in women with a BMI > 40 is technically possible, with no intra-operative conversions to open, but is associated with an increase in morbidity compared to women with a lower BMI. However, most patients still benefit from the laparoscopic approach as opposed to an open procedure. Laparoscopy should be considered the preferred route for surgery in this group of women.

FC20- Day Case Laparoscopic Burch for Genuine Stress Incontinence

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Introduction: Surgical management is available for those select patients with genuine stress incontinence, when conservative measures are unsuccessful.
Aim: Comparison of results in patients undergoing open and laparoscopic Burch colposuspension, as well as mid urethral tension free mesh for the surgical management options of genuine stress incontinence.
Method: Patients who presented with stress incontinence underwent Urodynamics studies prior to undergoing a surgical intervention. Laparoscopic Burch colposuspension, open Burch procedures as well as mid-urethral tape procedure between 1st Jan 2013 and 31st Dec 2014 were included in the study. The length of stay following the respective surgical intervention as well as the readmission rate were assessed.
Results: Fourteen patients underwent laparoscopic Burch procedure (age range between 37 to 72years) while fifteen patients underwent open Burch procedure (age ranged between 40 to 62years). Mid-urethral tape procedures was carried out on twenty patients. (age ranged from 37 to 71years). The average length of stay was 2.57days (ranging from 1-3days), 6.22 days (ranging from 4-9days) and 2.95 days (ranging from 1-9days) for laparoscopic Burch colposuspension, open Burch colposuspension and mid-urethral tape procedure respectively. There were no readmissions after laparoscopic Burch colposuspension while there were two readmissions after open Burch colposuspension and two readmissions after mid-urethral tape procedures.
Conclusions: Patients undergoing laparoscopic Burch procedure had a shorter hospital stay, quicker recovery and earlier return to work; as well as requiring no readmissions. It is envisaged that we achieve day case laparoscopic burch colposuspension for the management of genuine stress incontinence.

FC21- Feasibility of A Randomised Controlled Trial (RCT) to compare Recovery, Pelvic Floor and Sexual Function following Laparoscopic Total Hysterectomy with that following Laparoscopic Sub-Total (Supracervical Hysterectomy): The LaHoST study

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Background: Patient benefit following cervical conservation at abdominal hysterectomy remains unproven (Lethaby 2012). Numerous observational studies suggest an advantage of Laparoscopic Supracervical Hysterectomy (LSH) over Laparoscopic Total Hysterectomy (LTH). The only randomised comparison showed no difference (Morrelli 2007) but assessments may have been too infrequent to demonstrate a difference.
Aim: To assess the feasibility of an RCT comparing recovery, pelvic floor and sexual function following LSH with that following LTH.
Method: Premenopausal women with a benign indication for hysterectomy, uterine size of less than 16 weeks gestation and less than 2nd degree uterine descent were randomised to LSH or LTH. Participants were followed up weekly using validated recovery questionnaires until 12 weeks. In addition they were asked to complete validated pelvic floor and sexual function questionnaires at baseline, 6 weeks and 6 months.
Results: 50 of 70 eligible women agreed to randomisation. Data collection was complete at 24 months. 100%, 88% and 60% of recovery questionnaires were captured at baseline, 6 weeks and 12 weeks respectively. Recovery data between 7 and 12 weeks did not appear discriminatory. 98%, 90% and 76% of pelvic floor and sexual function questionnaires were captured at baseline, 6 weeks and 6 months respectively. Recovery to normal activity occurred at 4-5 weeks in the LSH group compared to 7-8 weeks in the LTH group.
Conclusions: An RCT to compare outcomes following LSH and LTH appears feasible. Those undergoing LSH appear to be back to normal 2 weeks prior to those undergoing LTH. No effect was observed on bladder, bowel or sexual function. We propose a larger multicentre study to investigate this important issue.

FC22- Outcome of reproductive surgery in sub fertile women with tubal disease

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Tubal disease accounts for at least 25% of female factor subfertility with more than half of the cases due to Chlamydia salpingitis. We have reviewed our reproductive surgical outcome in a group of 89 sub fertile women who underwent laparoscopic tubal surgery having had tubal co morbidities such as previous Chlamydia infection (75%) or endometriosis (25%). Tubal disease was graded laparoscopically.
The commonest surgical interventions undertaken were division of adhesions/ tubal surgery and HELICA coagulation of endometriosis. Occasionally, division of large hydrosalpinx, proximal tubal cannulation or total salpingectomy to prepare for IVF were performed. After the surgery, 51% of the patients who had Chlamydia induced tubal disease were referred for IVF indicating the significant damage this organism might cause to the fallopian tubes; and only 31% of those with negative Chlamydia serology needed IVF referral. The rest of the patients received either ovulation induction or had conceived naturally. Pregnancy rate was 40% in women who had Chlamydia induced tubal disease (3 had ectopic pregnancy) and 38% in those with negative Chlamydia serology. Although the recommendation for tubal disease favours assisted reproductive technique (ART), still tubal microsurgery has the advantage of long-standing restoration of fertility. The NICE Guideline favours laparoscopic tubal surgery for mild tubal disease and salpingectomy for hydrosalpinx before ART. Adequate counselling regarding the risks of surgery and ectopic pregnancy is paramount.
Proper laparoscopic grading of tubal disease with adequate counselling following consideration of clinical picture and patient`s preferences can result in a good success rate.

FC23- Combined laparosciopic ovarian tissue cryopreservation and retrieval of immature oocytes followed by in vitro maturation and vitrification: Results from the Oxford Ovarian Tissue Cryopreservation (OTCP) Programme

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Introduction: Combining ovarian tissue cryopreservation with retrieval of unstimulated immature oocytes followed by IVM and vitrification may potentially increase the prospects of fertility preservation in oncologic patients. No clear consensus is established whether a combined strategy should be utilized.
Aims: To study the feasibility of intraoperative egg retrieval in oncologic patients undergoing ovarian tissue preservation. The different surgical techniques utilized to be described.
Materials and Methods: A retrospective study of the first clinical ovarian tissue cryopreservation(OTCP) service in England. Oncology patients undergoing OTCP before high-risk gonadotoxic chemo-radiotherapy, were all offered immature egg retrieval, IVM and vitrification. Egg retrieval was done either by *ex situ* puncturing the ovary after excision or by percutaneous video-assisted oocyte pick-up in patients undergoing ovarian cortical strips resection, in addition to the fluid collection after tissue processing.
Results: The results of the first two years of activity at Oxford University OTCP Programme will be presented. . So far, 20 patients aged 2-31 years were recruited and undergone laparoscopic ovarian tissue harvesting and *ex situ* or *in situ* video-assisted egg retrieval. In 14/20 patients immature eggs were retrieved. The youngest patient with viable oocytes found, was 9 years old. Maturation rates and correlations will be presented. No major adverse events were experienced.
Conclusions: Oocytes can be retrieved by *ex-situ* puncturing of the excised ovary, *in situ* percutaneous video assisted egg retrieval during laparoscopy or from the processing fluid, then matured *in vitro*, and cryopreserved by vitrification. This fertility preservation modality could be combined with ovarian tissue preservation.

FC24- How to interpret presenting symptoms of ectopic pregnancy? The triad associated with major haemorrhage

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Introduction
Ectopic pregnancy (EP) occurs in up to 2% of pregnancies and can be life threatening (Barnhart 2009). The association between presenting symptoms and quantity of intra-peritoneal bleeding has not been assessed.
Methods
Prospective audit of all women requiring surgery for EP over a 5-year period at Whipps Cross Hospital. Secondary analysis of presenting symptoms and blood loss documented on the operation note was performed. We analysed the association of presenting symptoms with blood loss at surgery. Statistics were calculated with SPSS v.20, Mann-Whitey U-test was used to compare groups, significance at $p<0.05$.
Results
318 women underwent surgery for EP during the 5 year study period, Table. 1.

Symptom	n= (%)	Median age	p=	Weeks amenorrhoea	p=	Median EBL at surgery (mls)	Range	p=
Any	318 (100%)	30.7	-	6.5	-	425	0-4200	-
Vaginal bleeding	294 (9.2%)	30.7	0.101	6.5	0.917	416.0	0-4200	0.485
Abdominal pain	310 (97.4)	30.8	0.094	6.5	0.673	422.0	0-4200	0.359
Diarrhoea	3 (0.9%)	31.6	0.892	6.3	0.892	1200.0	0-3000	0.416
Vomiting	24 (7.5)	31.0	0.638	6.3	0.723	1293	0-4000	**<0.0001**
Shoulder tip pain	30 (9.4%)	32.5	0.22	6.6	0.688	1671.0	100-4000	**<0.0001**
Syncope	23 (7.2%)	31.6	0.603	6.6	0.65	1854.0	100-4000	**<0.0001**

Statistical comparison of group of patients with the stated symptom to those without it

EBL= estimated blood loss

Table. 1. Characteristics and blood loss at surgery in women with the stated symptom at presentation

The triad of vomiting, shoulder-tip pain and syncope were associated with significantly increased blood loss at surgery (Fig. 1), none was associated with increased blood loss when independent of the other two. Shoulder tip pain and syncope combined (median EBL 1520mls (0-2800), p<0.0001) and the triad combined (median EBL 2562mls (500-4000), p<0.001) were associated with significantly increased blood loss.

Conclusion- Vomiting and syncope are signs of hypotension, shoulder-tip pain signals diaphragmatic stimulation, in EP likely due to intra-peritoneal haemorrhage. Their association with greatly increased blood loss may not be appreciated by clinicians. Those managing women with EP and shared CEPOD lists must understand the necessity of urgent surgery and blood products for women with suspected or confirmed ectopic pregnancy with vomiting, shoulder-tip pain or syncope.

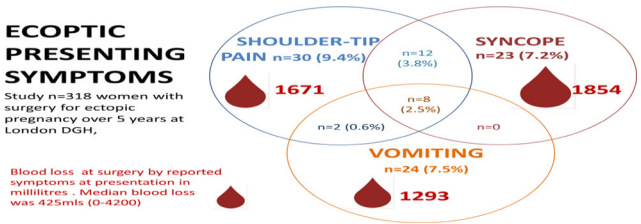

Figure 1. Summary Venn infographic

FC25- A Proposed Inexpensive Uterine Hysteroscopy Model for simulation-based Education

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BACKGROUND: In obstetrics and gynaecology practice, hysteroscopy is the standard procedure for diagnostic evaluation of the uterine cavity and for operative treatment of uterine abnormalities.[1,2] Diagnostic and operative hysteroscopy can be challenging and requires significant skill set and good hand-eye coordination. Simulation can benefit the trainee, educator and patient. Simulation allows for practice, real-time feedback, and learning in a safe environment.[3] A growing body of data supports the effectiveness of formal, objective teaching of surgical skills and the effectiveness of surgical simulation in training.[4] Additionally, for some clinical tasks, simulation training can be effective when inexpensive but realistic models are used.[5] However there is a relative paucity of simulation-based education in obstetrics and gynaecology training programmes. Besides, the existing simulators are expensive and trainees have limited access to them due to lack of resources.

OBJECTIVE: We propose an effective, inexpensive and reproducible model for developing the skills and hand-eye coordination for diagnostic and operative hysteroscopy.

METHOD: Advanced surgical skills can be practiced and improved using simple clay, play-doh uterine models. Four different clay, play-doh uterine models were developed, demonstrating techniques of diagnostic and operative skills including removal of mirena coil, resection and biopsy of endometrial polyp and cannulation of fallopian tubes. A rigid hysteroscope is simulated Using flexible snake scope camera, while a pipette was used to simulate a channel for operative hysteroscopy.

CONCLUSION: The described play-doh uterine models are a cost effective way to improve hand-eye coordination in the use of diagnostic and operative hysteroscopy.

Video Poster Presentations

FCVP1- 'Pockets and Pouches': Dangerous, Deceptive Endometriosis:

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Severe endometriosis can sometimes be very discrete and easily missed without a systematic thorough laparoscopic pelvic survey. Lesions can be hidden from view in a peritoneal pocket, or the pocket itself can be hidden behind other structures. This can lead to false negative laparoscopy or incomplete excision of disease.
Endometriosis can also cause subtle distortion of pelvic anatomy which on initial inspection can be unrecognised. Failure to recognise subtle bowel adherence creating a pouch can lead to major surgical complications. We present videos of 2 cases showing these pockets and pouches.
The first video demonstrates a significant endometriotic nodule situated deep within a peritoneal pocket in the recto-vaginal septum hidden from view behind the uterosacral ligaments. The video shows resection of the nodule by inverting the pocket to ensure complete excision of the disease.
The second case was referred for excision of "mild" endometriosis. There is subtle but significant tethering of the rectum creating a pouch up to the back of the uterus, which was previously missed at the first laparoscopy. The video shows release of the rectal tethering and the techniques employed to carefully resect the disease off the rectum. These two examples clearly demonstrate the misleading appearance of endometriosis and the traps that await both diagnostic and therapeutic laparoscopic surgery. Valuable lessons for us all.

FCVP3- VIDEO - Our first attempt at in-bag power morcellation

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Power morcellation has received a bad press recently due to the perceived risk of dissemination of inadvertant leiomyosarcomas.
A number of authors have advocated 'in-bag' morcellation.
This video demonstrates our first attempt to achieve in-bag morcellation of an ovarian fibroma. Particular attention is made on the methodology and difficulties encountered.
Overall, the procedure prolonged the operation by half an hour but we did not encounter many technical difficulties.

FCVP4- Teaching an old dog new tricks - A surgeon's first docking of the new Da Vinci Xi

Thomas Ind[1*], Ilyas Arshad[1], Marielle Nobbenhuis[1]
[1]*Royal Marsden Hospital London UK*

This is an unedited 10 minute video with sound. When a new Da Vinci Xi was purchased in our institution, one robotic surgeon had formal teaching in docking while another was taught in-house by the trained surgeon.
This video demonstrates how the Xi is docked in a real surgical setting and is an insight for those unfamiliar with robotic surgery. The video also shows the process of an established robotic surgeon being taught the new process.
It is clear from this video that even in a teaching setting, the process adds only ten minutes to the operation.

FCVP5- Extra-peritoneal laparoscopic colposuspension (EP-LC) for women with Stress Urinary Incontinence

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Introduction
Laparoscopic colposuspension has been shown to be equivalent to the open procedure in Cochrane reviews (1), however, it did not catch momentum due to the technical demand of the procedure the emergence of tension-free vaginal tapes (2).
Objective:
We present short-term follow up of the first 16 procedures performed by a simplified extraperitoneal approach.
Method:
Veress needle is introduced above the symphysis to insufflate 1L of CO_2 into the retropubic space (RS). Umbilical trocar introduced and rectus sheath is pierced midway between the umbilicus and the symphysis pubis. Recti are separated and the 'cob-web' of gas will guide the scope to RS. Two 5-mm trocars are introduced 2 cm above and 1 cm lateral to pubic tubercle. Using the usual perineo-abdominal approach, the vagina at the level of the bladder neck is dissected and attached to Cooper's ligaments with 2 non-absorbable sutures on each side. Straight needles with integrated knot-pusher are used. Data were extracted from BSUG national database.
Results:
16 procedures were performed over 18 months. 11/16 had pure and 5/16 had mixed incontinence. Mean BMI: 30.5 and mean age: 45.5. One patient required repair of bladder injury via laparotomy with no consequences.
3-month postoperatively, 15 patients were dry and 1 had persistent SUI. One patient developed de novo urgency and one required rectocele repair.
Conclusion:
EP-LC procedure appears to be a valid minimally-invasive alternative for women with SUI.
References:
1- Cochrane review. July 2006.
2- BJOG.2006; 113; 985-987.

FCVP6- A case of Ligasure failure to seal ovarian vessels in a patient with a history of ovarian vein emobilization during performing hysterectomy

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Case report
A 48 year old lady had a total laparoscopic hysterectomy for heavy and painful periods.
During the operation a Ligasure was used as an energy source to perform the hysterectomy. The infundibulopelvic ligament was cut successfully however; down near the anastomosis of the ovarian vessels with the uterine artery, the Ligasure repeatedly failed to initiate energy. It was thought that the Ligasure was faulty as the generator indicator kept illuminating indicating that the tissue has not been sealed. A closer look at the ovarian blood vessels, a spiral metal wire was found near the left pelvic side wall which was coming from the ovarian vein. The wire was removed laparoscopically and the rest of the operation was performed successfully.
From the history, this patient had had peripheral vascular disease. She had pelvic venography and left ovarian vein embolisation. As a part of the procedure, segment of titanium spiral wire is placed and left within the blood vessel.

Discussion
The Ligasure fails to seal vessels when the tissue impedance is out of range, the seal cycle was interrupted before the cycle was complete, insufficient amount of tissue inside the jaws of the ligasure or grasping metal objects; such as staples, wire, spiral, or clips; in the jaws of the instrument.
Conclusion
The clinicians should be aware that one of the reasons of the ligasure failure is a presence of metal object such as titanium wire between its jaws which can be hiden inside a blood vessel as in this case.

FCVP7- Introduction of a novel approach to maintaining Pneumoperitoneum at Total Laparoscopic Hysterectomy (TLH)

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During TLH diathermy is used to circumferentially cut around the uterine manipulator. At this stage CO_2 can be lost.
We have developed a fluid filled "donut" which can be placed inside the vagina. This maintains pneumoperitoneum at the time of removing the uterus from the vagina. Once the specimen has been removed the "donut" can then seal the lower vagina while suturing takes place in order to avoid loss of CO2.
The following equipment is required:

• condom
• silastic foley catheter N14
• 60ml syringe
• suture material for tying - silk 0/2
• Sterile water

1. The catheter is inserted inside the condom (3-4 cm of the catheter tip should be placed just inside the condom)
2. Silk is used to tie a knot about 1cm from the end of the condom so it is fixed to the catheter
3. The tip of the condom should be then be placed alongside the above knot.
4. The tip of the condom is tied in place using the suture material forming a donut
5. The integrity of the donut is checked by filling it with 60ml of sterile water via the catheter.
6. Following insertion of the uterine manipulator the donut isthreaded over the handle of the manipulator and pushed up the vagina close to the cup.
7. Prior to excising the cervix the assistant inflates the donut with sterile water.
8. Following removal of the specimen the donut is replaced in the lower vagina to ensure ongoing pneumoperitoneum.
https://vimeo.com/122824001

FCVP8- Hysterectomy for Filshie clip Migration

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Objective
To examine an example of rare Filshie clip migration.
Setting
The Filshie clip has become the most popular sterilisation device in the UK since its introduction in the 1980's[2]. There have been a number of case reports published describing migrated clips[3,4,5] and it has been suggested that migration can occur in over 20% of cases[6].
Case:
Following an uneventful laparoscopic Filshie sterilisation a 36 year old P3 was seen in clinic (by multiple different consultants) complaining of pelvic pain. Investigations including a diagnostic laparoscopy gave a high suspicion of an embedded Filshie clip between the vagina and bladder. Follow up appointments were missed. Re-referrals lead to multiple clinicians' involvement. There was no note of the surgical findings and emphasis on pelvic pain occurred. She eventually had a TAH BSO.
She was re-referred, seeing a different consultant, with swelling in the vagina and a suggested foreign body between the vault and bladder on MRI/USS. Cystogram confirmed no communication to the bladder.
The patient had a n excisional laparoscopy, which identified a nodule containing an old abscess and a Filshie clip was retrieved from within.
Discussion
There was discontinuity of the patient care that has become common practice since the NHS plan[7]. This has led to the abandoning of named consultants and instead the use of clinician pools. The result is loss of clinical information and incorrect diagnostic pathways taken. It seems likely that, had the patient returned to the consultant performing the initial laparoscopy, perhaps hysterectomy would have been avoided.

FCVP9- Prophylactic skeletonisation of infundibulopelvic vessels and temporary clipping of bilateral uterine arteries during myomectomy for large sub mucous fibroid

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Introduction
Randomized trials have demonstrated that laparoscopic myomectomy is associated with decreased morbidity and quicker recovery. However, it can be associated with considerable blood loss. Temporary clipping of bilateral uterine arteries is shown to decrease blood loss during myomectomy without affecting uterine perfusion. In addition, prophylactically skeletonising infundibulopelvic vessels and placing a loose knot around them can provide extra security to enable quick bleeding control if required.
Video Presentation
In our video presentation of a laparoscopic myomectomy for a large fibroid uterus, we demonstrate lateral pelvic sidewall dissection, ureterolysis, temporary clipping of bilateral uterine arteries, prophylactic skeletonisation of infundibulo pelvic vessels and myomectomy for a large fibroid uterus.

Following steps were undertaken:

1. Trocar placement was individualized to ensure easy manipulation
2. Pelvic survey was performed and bilateral ureters were identified
3. Right infundibulo pelvic vessels were skeletonised as these were particularly large. A loose knot was placed around the IP ligament prophylactically to be tightened in case of significant bleeding.
4. Peritoneum covering bilateral lateral pelvic sidewalls was opened and bilateral ureterolysis was performed
5. Uterine arteries were identified
6. Vascular clips were placed loosely over bilateral uterine arteries
7. Vasopressin was infiltrated over the myometrium covering the fibroids
8. Myomectomy and multiple layers of suturing were performed.
9. At the end of the myomectomy, bilateral vessel clips and temporary tie were removed
10. Haemostasis was reconfirmed after removing clips

Blood loss during surgery was minimal and the patient was discharged the next day.

FCVP10- Management of a large torted dermoid with a viable ovary: de-torsion with orchidopexy and interval cystectomy or de-torsion and cystectomy?

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Introduction
Follow up of women of reproductive age who underwent de-torsion of torted ovaries has revealed resumption of ovarian function and successful pregnancies. Where there is a torted viable ovary with a large ovarian cyst, the choice is either to de-tort, perform orchidopexy and perform interval ovarian cystectomy or to de-tort and perform cystectomy to reduce the risk of re-torsion and repeat surgery.
Video Presentation
We present the case of a 30 year old with a known 12cm right dermoid. While awaiting elective surgery, she presented with classical signs of torsion. Prompt laparoscopy revealed that the cyst had torted 4 times around the utero- ovarian ligament. The ovary had a bluish hue but regained colour immediately after de-torsion. There was no obvious oedema. An uncomplicated ovarian cystectomy was performed but the cyst ruptured during the process. A thorough lavage was performed.
3 months after the procedure, the patient underwent a repeat laparoscopy for pelvic pain, which revealed a frozen pelvis, bilateral hydrosalphinges and an ovarian mass on the right side. Adhesiolysis, partial right oophorectomy and pelvic lavage were performed. Our differential diagnosis was: chemical peritonitis, pelvic infection post surgery and severe PID. The patient needed another pelvic lavage following which she recovered completely.
We present pictures and videos from the laparoscopic procedures and also discuss in detail the management of large torted ovarian cysts in women of the reproductive age group.

FCVP11- Video presentation of 2 different approaches for complex salpingo-oophorectomy

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Salpingo-oophorectomy is a common gynaecological operation. Increasing ovarian preservation at the time of hysterectomy, leads to more complex surgery to be required later in the woman's life. We present 2 different approaches to manage intraoperative access difficulties.
Case1: Frozen pelvis due to severe endometriosis. Unilateral salpingo-oophorectomy was performed for a large endometrioma in a patient with severe pelvic pain wishing for fertility. Ureteric stents inserted to facilitate identification at ureterolysis. Severe adhesions and fibrosis necessitated an unusual approach. Starting medially at the ovarian ligament and fallopian tube, ligating laterally. The ovary was stuck to sigmoid colon. The POD was obscured. The round ligament was divided, the ovary was medialised, the ureter identified and lateralised. The IP pedicle was divided last.
Case 2: Dense adhesions on entry were obscuring the pelvis due to previous hysterectomy.This patient was fully anticoagulated for cerebral vein thrombosis. We show a systematic adhesiolysis normalising the pelvis. Then, anatomical salpingo-oophorectomy is shown starting from the IP ligament. Once the pelvis was visualised, the ureter identified transperitonially. Meticulous haemostasis was achieved. Adhesiolysis and raw surfaces for dissection kept to a minimum. In this case ureter lateralised and IP ligament divided.
Conclusion: Laparoscopic surgeons need to build have a wide armamentarium of techniques to adapt to the challenges encountered intraoperatively safely.

FCVP12- Incidental finding of well differentiated papillary mesothelioma of the fallopian tube: a rare differential diagnosis of endometriosis at laparoscopy

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Well differentiated papillary mesothelioma (WDPM) is a mesothelial tumour that occurs in the peritoneum but rarely on the fallopian tube. A 36 year old nulliparous patient presented to gynaecology out-patients clinic with a 3 month history of lower abdominal pain, dysmenorrhoea and menorrhagia. Ultrasound scan found a complex ovarian cyst of the left ovary measuring 7cm in diameter. Magnetic resonance imaging suggest a 7cm endometrioma, adenomyosis and rectovaginal endometriosis. A plan for laparoscopic ovarian cystectomy and staging of endometriosis was arranged.
At laparoscopy the left fallopian tube had an unusal appearance, was swollen with mutiple psedocysts attached that was suggestive of endometriosis. A left salpingectomy, left ovarian cystectomy and excision of pelvic endometriosis was performed. Histology of the left fallopian tube showed well differentiated papillary mesothelioma while ovarian cyst wall and pelvic peritoneal biospy showed endometriosis. Our patient made an uneventful recovery and will now be followed-up with a interval diagnostic laparoscopy and perinteal biopsy to exclude multifocal disease.
WDPM is generally considered a tumour of low malignant potential, although little is known regarding its natural history and there are no consensus for its management. This case highlights its appearance at laparoscopy and the importance for histological diagnosis of endometriosis.

FCVP13- Unusual presentation of ovarian cyst, successful laparoscopic excision

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We are here with presenting a successful laparoscopic excision of an unusually presenting dermoid cyst as a video presentation.
A 25 yrs old lady presented to Emergency unit with left side lower abdominal pain. She underwent extensive investigations, CT scan revealed large 14+12+19 cm cystic lesion in the upper quadrant, suggestive of dermoid cyst. Tumour markers were normal.
Ovarian cyst present in upper abdomen, mimicking mesenteric/splenic cyst.
As she was symptomatic, was offered laparoscopic excision of ovarian cyst with or without oophorectomy.
She underwent laparoscopy, cyst was removed without spillage into peritoneal cavity. Procedure was uneventful. Histology confirmed mature cystic teratoma.

FCVP14- Practical and anatomical advantages of uterine suspension for access optimisation in resection of deep infiltrative and rectovaginal endometriosis (video and animation)

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Radical surgical excision of deep infiltrative endometriosis (DIE) is the current mainstay of treatment. Optimal surgical access is crucial for achieving good results. In our experience temporary suspension of the uterus, in addition to that of the adnexa, provides superior exposure than conventional uterine manipulation. We demonstrate the advantages of this technique via a short video and an animation that outlines the relevant anatomical relations.
The technique involves the passing of a 2-0 prolene suture on a straight needle through the skin suprapubically into the pelvis under direct vision. The needle is then passed through the uterine fundus in a dorsal to ventral direction and subsequently taken out through the anterior abdominal wall right by the original entry point. The suture is either tied extracorporeally over a Raytec gauze or clipped on a heamostatic clamp, so as adjustment of the degree of anteversion during the procedure is readily achievable. The same result can be achieved by a modified version of the technique, whereby a large curved needle is passed through the uterine fundus and the suture is retrieved through the skin by use of a rectus sheath closure device.
Temporary uterine suspension results in a better-exposed and still operating field due to avoiding excessive manoeuvres from the second assistant, especially when concomitant rectal manipulation is warranted. It is a

rather easy and quick method of enhanced exposure of the surgical field; hence we advocate its routine use where resection of endometriosis from the cul-de-sac and uterosacral ligaments is required.

FCVP15- Laparoscopic ventrosuspension as treatment for dyspareunia and dysmenorrhea: Another nice operation that doesn't work?

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Mobile uterine retroversion has long thought to be the cause of pelvic pain symptoms. Various reports stemming mainly from uncontrolled cohort studies over the last 20 years have shown inconsistent results of surgical correction of acute uterine retroversion. More recent data from medium and long-term observational studies, however, suggest that despite some decline in the overall effect of surgical ventrosuspension with time, symptom improvement is durable in about 50% of cases.

Amid ongoing debate amongst laparoscopic gynaecologists about the efficacy of this method, we present two cases in which we performed laparoscopic ventrosuspension, hoping to reproduce the promising results reported in the literature. Both cases regarded premenopausal women presenting with severe persistent pelvic pain and no other intraoperative findings apart from an acutely retroverted uterus and elongated round ligaments.

A non-absorbable suture was placed at the most lateral aspect of each round ligament, at the point of its entry into the internal inguinal canal and tied laparoscopically. A running suture was continued medially, using several bites around the round ligament and tied to the short end of the initial lateral knot, resulting in shortening of both round ligaments and an axially positioned uterus.

No symptom improvement was evident at 3 months postoperatively in either of the cases. Although failure of this method in a small case series can not question the results in much larger cohorts, we remain unconvinced that correcting a finding that is present in around 15% of asymptomatic women can be an effective treatment for pelvic pain.

FCVP16- A failure of the Novasure Cavity Integrity Assessment (CIA) due to tubal patency: a video presentation. Dr Monika Oktaba, Mr Andrew Baxter, The Royal Hallamshire Hospital, Sheffield, UK

Andrew Baxter[1], Monika Oktaba[1*]
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A video will be presented demonstrating a failure of the Novasure Cavity Integrity Assessment (CIA) due to gas flow down a Fallopian tube. The ablation was being performed as part of a combined procedure and when the CIA would not pass it was noted laparoscopically that CO2 was flowing from the fimbrial end of one of the tubes. When this tube was clamped proximally the flow ceased and the CIA passed. A video demonstrating the sequence of events clearly will be presented and discussed. This potential problem is not mentioned in device literature. If this phenomenon is more than an isolated event it could lead to:

- trauma to the cervix in attempts to seal an 'incompetent' cervix
- unnecessary hysteroscopic checks of the cavity
- wasted devices
- if no other technique available, patients potentially having an unnecessary GA without an ablation being performed

It would be interesting to know the incidence of 'failed' Novasure procedures and whether this tubal cause of a failed CIA is a major contributing factor.

FCVP17- TITLE: A Junior Trainee: Laparoscopic salpingectomy for ectopic pregnancy

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Developing skills for laparoscopy is an essential part of our training curriculum in Gynaecology. As an ST3 in Obstetrics & Gynaecology, with an interest in laparoscopy, I have been developing skills under senior supervision. Having achieved competence in diagnostic laparoscopy, I am now gaining confidence in simple minimal access procedures. I am in a privileged position training in a unit with regular laparoscopic lists, where consultants and senior registrars alike are highly experienced and confident in supervising juniors.

The most common laparoscopic procedure that trainees will be expected to do and should be competent to carry out independently by ST6 is a laparoscopic salpingectomy. It is a valuable skill if you are the senior presence out of hours, in order to treat the acute admission of an ectopic pregnancy, when your consultant may be delayed in attending.

I show two videos comparing two techniques, both useful in their own right.

1. Bipolar and cold scissors: Achieves full excision of the fallopian tube, without leaving a tubal stump. A favourite of reproductive medicine specialists, who fear stump ectopics in the event of an incompletely excised tube. However, often time consuming, with the need for frequent swapping of instruments and a potentially dangerous tool near neighbouring bowel.
2. Loop excision: a more simple but effective method. Enables quick haemostasis in the event of rupture or active bleeding and usually prevents the need for diathermy. An efficient method to allow the ever pressured registrar to return quickly to their duties on labour ward.

FCVP18- A video illustration of a proposed cost effective uterine hysteroscopy simulator

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BACKGROUND: In obstetrics and gynaecology practice, hysteroscopy is the standard procedure for diagnostic evaluation of the uterine cavity and for operative treatment of uterine abnormalities.1,2 Diagnostic and operative hysteroscopy can be challenging and requires significant skill set and good hand-eye coordination. Simulation can benefit the trainee, educator and patient. Simulation allows for practice, real-time feedback, and learning in a safe environment. 3 A growing body of data supports the effectiveness of formal, objective teaching of surgical skills and the effectiveness of surgical simulation in training.4 Additionally, for some clinical tasks, simulation training can be effective when inexpensive but realistic models are used.5 , however there is a relative paucity of simulation-based education in obstetrics and gynaecology training programmes. Besides, the existing simulators are expensive and trainees have limited access to them due to lack of resources.

OBJECTIVE: We propose an effective, inexpensive and reproducible model for developing the skills and hand-eye coordination for diagnostic and operative hysteroscopy.

METHOD: Advanced surgical skills can be practiced and improved using simple clay, play-doh uterine models. This video describes Four different clay, play-doh uterine models, demonstrating techniques of diagnostic and operative skills including removal of mirena coil, resection and biopsy of endometrial polyp and cannulation of fallopian tubes. A rigid hystroscope is simulated Using flexible snake scope camera,while a pipette was used to simulate a channel for operative hysteroscopy.

CONCLUSION: The described play-doh uterine models are inexpensive, effective, reproducible and can be used to improve hand-eye coordination in the use of diagnostic and operative hysteroscopy.

FCVP19- Efficacy and safety of laparoscopic sacrocolpopexy for post hysterectomy recurrent vaginal prolapse

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Aim: To prospectively evaluate the efficacy and safety of laparoscopic sacrocolpopexy for the management of post hysterectomy recurrent vaginal prolapse
Methods: 160 consecutive women who underwent laparoscopic sacrocolpioopexy for recurrent post hysterectomy vaginal prolpase were prospectively evaluated over a 5-year period. Sacrocolpopexy was performed with a Y shaped mesh after dissection of the vagina from the rectum and the bladder. Patients were assessed at 3, 12 and 24 months using the Prolapse Quality of Life (P-QOL) questionnaire; Patient Global Impression of Improvement (PGII) and were examined using the Pelvic Organ Prolapse Quantification system (POP-Q).
Results: 88% of patients reported complete cure of vaginal bulge symptoms. 92% reported feeling "much better" or "very much better" on PGII. 15% had recurrent anatomical prolapse defined as point Ba ≥ -1, which were asymptomatic apart from eight patients (5%) that underwent further surgery. Postoperatively, vault support (point C) was at stage 0 in all patients. Two patient developed vaginal mesh extrusion that needed surgical revision.
Conclusion: Laparoscopic sacrcolpopexy with Y shaped mesh placement is safe and effective treatment for recurrent vaginal wall prolapse up to 2 years follow up. The procedure had minimum complications and should be considered the gold standard in recurrent prolapse.

FCVP20- Resection of large endometriotic nodule from bladder with full thickness bladder wall resection

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A 27 year old underwent laparotomy by a gynaecologist and urologist elsewhere. Her bladder nodule was not tackled as it was felt by both surgeons to be too large to safely remove without diminishing bladder capacity.
At the age of 30 she was referred to the University Hospital of Wales, Cardiff, Endometriosis Centre for further management. She complained of severe dysmenorrhea, constant pelvic pain, menstrual haematuria, and cystitis like symptoms during and after her period. On cystoscopy she was found to have visible endometrioma sub mucosally above the right ureteric orifice and protruding into the lumen of the bladder.

Operative Laparoscopy

Following cystoscopy and bilateral ureteric stenting under X-ray guidance she underwent laparoscopic excision of bladder endometriosis.
The bladder dome was welded to the anterior uterine wall by a large endometriotic nodule occupying the utero-vesical fold. The extensive disease in her posterior compartment was not addressed on this occasion The nodule was bisected transversely using a monopolar hook. The bladder was then separated from the lower uterus. The remaining endometriotic tissue was shaved off the uterus, and bladder to leave healthy bladder tissue. The bladder was repaired with continuous 3/0 Vicryl suture. The patient was discharged the next day with an indwelling catheter which was removed 10 days later after a normal cystogram.
Ureteric stents were left in situ and will be removed following the second stage of her operation when her recto vaginal and pelvic endometriosis will be addressed.

FCVP21- Laparoscopic excision of rudimentary uterine horn with a failed pregnancy at nine weeks gestation

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Rudimentary horn pregnancies are rare and have an estimated incidence of 1 in 76 000 to 150 000 pregnancies. We present a case of a failed rudimentary horn pregnancy at 9 weeks gestation managed by interval laparoscopic excision and morcellation.
A 34 year old Para 1 lady initially presented with a delayed miscarriage diagnosed on ultrasound scan outside of NHS services. Images on repeat ultrasound scan were suggestive of an ectopic pregnancy but at laparoscopy a rudimentary uterine horn pregnancy was diagnosed. A single dose of methotrexate was given in this case to reduce vascularity of the rudimentary horn before an interval procedure four weeks later to complete excision. Magnetic Resonance Imaging(MRI) was used to assess pelvic anatomy and demonstrated communication between both uterine horns. At surgery an advanced energy source was used for tissue dissection and intra-corporeal suture ligation was used to achieve haemostasis. The excised rudimentary horn was removed by morcellation and the fetus was retrieved separately intact.
This case highlights the need for a high index of suspicion for uterine anomalies at ultrasound scan and also demonstrates techniques common to other laparoscopic procedures. Our literature search found that although most rudimentary horn pregnancies have been managed by laparotomy in the past there is an increasing number of cases managed laparoscopically and this appears to be as safe and effective.

FCVP22- Demonstrating the advantages of 3D laparoscopy, the precision of operating in small spaces; case of severe endometriosis with complex adhesions due to previous midline laparotomy and caesarean section

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Objective
3D laparoscopy needs to be appraised outside research laboratories. Its value in enhanced detailed visual navigation in narrow spaces is demonstrated in multiple adhesions and endometriosis.
Case
A 35y female with previous caesarean and long midline laparotomy while young to correct pyloric stenosis had long standing pelvic pain, dyspareunia and dysmenorrhea despite mirena inserted 3y ago. Examination indicated BMI of 32 and scarred abdomen from previous operations. Pelvic examination indicated tender bulky immobile retroverted uterus with scarred Douglas Pouch. Ultrasound and CT indicated Left complex 10x12cm adnexal mass towards the benign end of the spectrum with raised series of Ca125 but values less 200.Patient agreed for laparoscopic adnexectomy.
Methods and Results
Palmers point was used to introduce 10mm 3D Einstein vision technology scope. Findings indicated extensive adhesions creating difficult access to the pelvis which was scarred from endometriosis and previous caesarean and filled by left sided big endometrioma. Extensive adhesiolysis was performed with great accuracy and the added depth appreciation helped operating in confined spaces. The added feature of autonomous scope warming kept the view steady and avoided the interruptions to defog scope lenses. No difficulty was experienced by surgeons and staff in using the system and left salpingo-oophrectomy was achieved. Patient made

full recovery and discharged home after 24h and the follow up reported improved symptoms and return to normal function
Conclusion
In advanced laparoscopic gynaecology surgeons should consider 3D laparoscopy and adopt its benefits of improved vision and depth perception particularly in complex cases.

FCVP23- Laparoscopic Management of Residual Interstitial Pregnancy

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Interstitial ectopic is reported in 2 to 4% of all ectopic pregnancies. The management can be challenging even where diagnosis is made in a timely manner, before potentially life-threatening rupture has occurred. Surgical management carries an increased risk of bleeding due to a high vascularity of interstitial part of the uterus. We encountered a case where repeat laparoscopy was required 4 weeks after incomplete removal of an interstitial ectopic pregnancy.
Methods: We demonstrate the laparoscopic management of an incompletely removed interstitial ectopic pregnancy.
Results: A patient presented with suboptimal rise of βHCG. Following an ultrasound diagnosis of tubal ectopic pregnancy, laparoscopic salpingectomy was performed. However, βHCG continued to rise with a maximum level of 12500iu/l following surgery. A repeat ultrasound scan showed presence of residual interstitial ectopic pregnancy. Patient declined medical treatment and opted to have a surgery. During the repeat laparoscopy, adhesions and postoperative inflammatory changes were found, making tissue more vascular and friable. However laparoscopic removal of residual trophoblastic tissue with intra-corporeal suturing of the uterus was successfully performed. The patient recovered uneventfully.
Conclusion: Laparoscopic removal of residual interstitial ectopic pregnancy is feasible and should be attempted. This video will demonstrate the steps that were undertaken to do this successfully.

FCVP24- Laparoscopic management of a ruptured interstitial pregnancy associated with massive haemoperitoneum and history of ipsilateral salpingectomy

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Interstitial pregnancy is an ectopic pregnancy which is implanted in the interstitial part of the fallopian tube, the part that transverses the myometrium. It accounts for 2-4 % of all tubal gestations. Mortality rates are reported as being between 2-2.5 %. The commonest risk factor is history of ipsilateral salpingectomy. Traditional treatment, particularly in cases of haemodynamically unstable patients, has been by laparotomy. Literature review reveals that a few such cases have been managed by laparoscopy and either cornual resection and suturing or suturing alone.
Our patient presented with low abdominal pain at 7 weeks gestation. She was para 1 with one previous caesarean section and a right laparoscopic salpingectomy for previous ectopic pregnancy. Her beta-hCG was approximately 6000 mIU/ml and her haemoglobin 13.5 g/dL. Ultrasound examination showed a left adnexal mass and small amount of free fluid raising the suspicion of a left-sided ectopic. She was scheduled for a laparoscopy. Over the following hours she became tachycardic and hypotensive, her haemoglobin dropped to 9.5 g/dL and the procedure was expedited. At laparoscopy massive haemoperitoneum was seen, the left adnexae appeared normal and a ruptured right interstitial pregnancy was diagnosed. The pregnancy tissues were removed and the uterine wound repaired with intracorporeal suturing. The estimated blood loss was 2.5 lt. Post-operative recovery was uneventful and the beta-hCG levels dropped rapidly.
In conclusion, ruptured interstitial pregnancy with massive haemoperitoneum may be managed safely by laparoscopy, provided the required skills and the option to quickly convert to a laparotomy are in place.

FCVP25- Diagnostic and Intra-operative Challenges for Ovarian Ectopic Pregnancy, Including Ovarian Conservation

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Up to three percent of ectopic pregnancies develop in the ovary, thought to be subsequent to fertilisation prior to ovulation, implantation on the ovarian surface or presence of endometriosis. They can be technically difficult to diagnose on ultrasound scan and may well be an unexpected finding at laparoscopy. There is some suggestion that the presence of an IUCD may be a pre-disposing factor and that they may be more likely when conception follows IVF treatment.
We show two cases of ovarian ectopic pregnancy, both diagnosed by pre-operatively on ultrasound and managed with conservation of ovarian tissue at University College London Hospital.

FCVP26- Laparoscopic CESA (CErvical SAcropexy) guided by retroperitoneal tunnelling: an anatomic reconstruction

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Case summary
A 56 year old woman presented with symptomatic stage 3 utero-vaginal prolapse.
Procedure
A laparoscopic subtotal hysterectomy was performed. Then a one centimetre peritoneal window was created over the S2 vertebral body on either side. A PVDF mesh is sutured onto the cervical stump using ethibond. A tunnelling device was inserted through one of the windows and advanced toward the cervical stump. The proximal end of one arm of the mesh is grasped by the tunnelling device and retracted through the retroperitoneal tunnel. This manoeuvre is performed on the contralateral side. These 8 cm arms form the *neo*-uterosacral ligaments. Then the proximal ends of the mesh is secured to the S2 body with ethibond. The peritoneal windows are closed.
Patient was discharged on day two. Post-operative follow up at 8 week revealed excellent anatomical support and functional results.
Discussion
We describe a laparoscopic modification of the traditional open sacropexy with the added advantage of a near normal anatomical support. The arms of the mesh comprise of non-absorbable sutures; not mesh. There are three mesh segments – a distal cervical segment and the two sacral components.
In view of the much small volume of mesh and a more anatomical support, we feel that this technique is safer than the traditional procedure.
A limitation of this technique is that it does not addressing the anterior or posterior compartment defects. In our experience, correction of the apical compartment obviates the need for further repair. Long term results are awaited.

FCVP27- A video illustration for morcelation in a bag Laparoscopic Supracervical Hysterectomy (LASH):

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Majority of hysterectomies are performed for benign conditions (***Einarsson JI, et al, 2009***).

Objective:
To assess the safety, reproducibility and cost efficacy of LASH. We compared the cost effectiveness of LASH and open subtotal hysterectomy and intruduced morcellation in bags towards the end of the audit.
Methods:
Data was collected retrospectively from 143 of women who underwent LASH from August 2008 - November 2014 for various benign indications with normal cervical smears and endometrium. Patients towards the end of the study had morcellation in bag in a way to comply with the recent FDA safety advice and it seems that operating time is getting better with learning curve.
Results:
3.4% had wound infection however only one pelvic haematoma, one ureteric oedema, one uterovaginal fistula, one hernia from lateral port site and one had scar pain at morcellator porte. No conversion to laparotomy, no blood transfusion, no DVT and no return to theatre. Average theatre time was 70 minutes for open subtotal hysterectomy and (90 min for LASH 15 min. for bag morcellation). The average cost per minute is £3.08.
Instruments for LASH costs £1156 plus cost of bag variable versus £200 for open. The average stay for LASH was 1.7 nights versus 3.7 nights for open. Average cost per night was £486. Overall cost of LASH was £2259.2 versus £2213.8 for open.
Conclusion:
LASH is safe, reproducible, cost effective and quicker recovery and less complication rates and can comply with FDA uterine morcellation advise.

FCVP28- A combined cystoscopic and laparoscopic approach to resect a full-thickness deep endometriotic nodule from the bladder

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Setting: A French university hospital.
A 34-year-old nulliparous woman with a large (35-mm) endometriosis nodule infiltrating the bladder and deep endometriotic lesions of the rectum and sigmoid colon.
Intervention: The urological surgeon has performed cystoscopy to identify the limits of mucosal involvement, and incised the muscular layer up to the subcutaneous tissue surrounding the bladder. The gynecological surgeon identified and followed the circular incision, and completed full-thickness resection of the bladder wall to isolate large nodule. Surgical technique reports in anonymous patients are exempt from ethical approval by the institutional review board.
Measurements and Main Results: The patient's functional outcome was better. The laparoscopic resection of large endometriotic nodules of the bladder per se may lead to inadvertent removal of healthy bladder muscle. Thus, it increases the risk of postoperative complications and symptoms due to small bladder volume. Conversely, if resection of the nodule is performed only cystoscopically, it probably would not be completely removed. The combined approach enables to complete resection of the endometriotic nodule. It not only averts the risk of excessive removal of healthy bladder muscle but also leaves no disease behind.
Conclusions: On the basis of our experience, we propose the combined cystoscopic and laparoscopic approach in managing large endometriotic nodules with full-thickness infiltration of the bladder.

FCVP29- Very big cervical broad ligament fibroid, an intraoperative surprise during laparoscopic hysterectomy; a demonstration to deal with the unexpected finding, a strategy to manage retroperitoneal masses

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Objective
It is recommended to exercise the best pathways in preoperative assessment to reduce intraoperative uncertainty before committing theatre resources and time. An unexpected big retroperitoneal mass was managed laparoscopically and retrieved vaginally.
Case
45y para 4 female presented with pain, pelvic mass and normal Ca125. Scans indicated 9cm right adnexal mass suggesting a big dermoid. On examination there was palpable mass at the right iliac fossa which was mobile and filled the Douglas Pouch. She opted for pelvic clearance given other symptoms of dysmenorrhea and dyspareunia.
Methods
Laparoscopy indicated rather a very big mobile retroperitoneal mass occupying the whole right broad ligament and consistent with cervical fibroid pushing the uterus to the left of the pelvis. The Vcare manipulator was actually in the fibroid rather than the uterus. Pelvis sidewall dissection was meticulous and achieved full mobilisation down to the origin of the fibroid. Hysterectomy was concluded laparoscopically and the specimen was retrieved vaginally after morcellation. Alexis retractor were used to protect vaginal walls. Total operative time was 315mins with 30min break in the middle. The estimated blood loss was 200ml and cystoscopy at the end of the procedure was reassuring. The specimen weighed 730gms.
Results
She made full recovery and discharged home after 48 hours. Follow up at 6 weeks indicted no complication and normal return to function and patient satisfaction. Histology confirmed benign fibroid.
Conclusion
Operative time cannot always be accurately predicted. It is better to have the resilience and skill to deal with unexpected intraoperative findings laparoscopically when possible.

FCVP30- Case report: An interesting case of complex pelvic pathology associated with subfertility – demonstration of investigative work up and operative management

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Case Report
A 38 year-old nulliparous woman presented to the fertility clinic with a history of recurrent first trimester miscarriage. She had a regular menstrual cycle associated with dysmenorrhoea and previously treated chlamydial infection but no other relevant medical or surgical history. Blood tests suggested normal ovulation, thrombophilia and endocrine screen was negative and both patient and partner karyotype was normal. Transvaginal ultrasound demonstrated a bulky uterus with a 5cm sub-serous fibroid, a right ovarian dermoid cyst and a possible left ovarian endometrioma. MRI further identified a bi-cornuate uterus and showed the 76mm sub-serosal fibroid arising from the posterior myometrium and projecting posteriorly to the left pelvic side-wall. The right kidney was seen within the pelvis, abutting the right ovary, which contained the dermoid cyst.
Management options were fully discussed and the patient counselled with regard to potential impact on fertility and future pregnancies if surgery was undertaken along with explanation of the risk of oophorectomy and hysterectomy. A CT IVU was performed pre-operatively to delineate the urinary tract in relation to the pelvic structures and help plan surgical approach.
Laparoscopy confirmed the pelvic imaging findings as well as rectovaginal endometriosis and bilateral endometriomas. Hysteroscopy identified a uterine septum. The patient underwent laparoscopic myomectomy, with extensive adhesiolysis, right ovarian cystectomy and hysteroscopic septoplasty.
Discussion
We present the full review of this case of subfertility along with relevant USS, MRI and CT imaging for discussion. The video presentation

contains demonstration of anatomical variation and pathology and the surgical techniques for management.

FCVP31- Stretching laparoscopic instruments to their limits, a case of of total laparoscopic hysterectomy of big fibroid uterus weighed>1000gm

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Introduction
There are case reports and series of laparoscopic hysterectomies with very large weights. There are not well defined limitations to laparoscopic approach. Intraoperative assessment is important to check mobility and access to the sidewall of the pelvis to allow progression with laparoscopic route.
Case
49y female with previous two vaginal deliveries presented to the surgical team with pyrexia, with acute abdominal pain and pyrexia with pelvis mass up to the umbilicus. She was also anaemic from menorrhagia for more than 6 months required antibiotics and blood transfusion and imaging indicated 14x12x13 uterine complex mass causing right hydronephrosis. She improved on conservative measures with Esmya and booked for hysterectomy with the intention of intraoperative assessment for laparoscopic hysterectomy.
Methods
Using 10mm scope with 30 degree angle at Palmers point it was possible to easily access the left side of the pelvis with bladder reflection. Mobilising the right side was difficult as the whole uterus was rotated and pressing on the sidewall but ultimately achieved. G2 Enseal articulating sealing device was particularly useful. Retrieval was done vaginally with the help of Alexis ring retractor to protect vaginal walls and vault was closed vaginally. Part of a laparoscopic grasper was missing intraoperatively.
Results
This was retrieved separately at a later procedure within 24h and ultimately patient made full recovery. The specimen weighed 1100gm and histology indicated necrotic infected fibroid.
Conclusion
Achieving laparoscopic hysterectomy is still the least traumatic route with the best enhanced recovery if safely achievable. However, the weight and mobility of the uterus can put significant strains on laparoscopic instruments

Poster Presentations

P1-A case of incarcerated and calcified GyneFix intra-uterine device successfully and safely removed endoscopically

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Introduction
A case of intrauterine incarcerated and impacted GyneFix IUCD is described. It was removed successfully hysteroscopically.
Case report
A 55 year old woman was referred to the Gynaecology outpatient clinic. Her GP had attempted to remove the Gynaefix however, it was found to be firmly fixed and traction on the strings caused considerable pain to the patient. The patient underwent hysteroscopy and D&C and removal of incarcerated GyneFix. The GyneFix was found calcified and incarcerated at the fundus of the uterus and was removed hysteroscopically.
Discussion
The GyneFix is a "frameless" IUCD, consists of six copper sleeves, each 5 mm long and 2.2 mm in diameter.(1) It is inserted by a needle through knot, at a depth of 1 cm, into the fundal myometrium. Due to its frameless design, flexibility, and minimal presence in the uterine cavity, the GyneFix is associated with few expulsions and dysmenorrhea than the IUCDs.
An incorrect technique may increase the risk of perforation.(2) The fact that the GyneFix was found calcified, suggests that it had been partially perforating the myometrium. However, the patient did not manage to conceive after the insertion of the coil. A frameless device anchored in the myometrium might erode through more easily than a framed device.(5)
Conclusion
Although it is rare, the possibility of incarceration, migration and late perforation highlights the importance of the routine regular post insertion check up. Incarcerated or partially perforating GyneFix can be safely removed hysteroscopically.

P2- A close shave in the management of rectovaginal endometriosis

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Introduction: Endometriosis affects bowel in 3-37% of all cases. There is ongoing debate regarding the necessity of either segmental resection or full-thickness disc rectal excision. This study aimed to review the use of the laparoscopic rectal shave technique to assess outcomes and patient satisfaction.
Methods: A retrospective database was established for patients requiring operative management of rectovaginal endometriosis between 2009 and 2014. Both electronic records and case notes were reviewed and data was collected on pre-operative symptoms, surgical procedure, length of stay, complication and re-admission rates and post-operative symptom recurrence. In addition patients answered a telephone satisfaction questionnaire.
Results: 52 patients underwent surgery during the study period with 69.2% carried out by a combined colorectal and gynaecological surgical team. Average age was 33.9 (21-43). Out of 52 patients 90% underwent rectal wall shave, 8% had segmental resection and 2% hysterectomy in combination with rectal shave. Surgery was performed laparoscopically in 96% with a 0% conversion rate. Average length of stay was 1.5 days with a re-admission rate of 5.8%. Major complications occurred in 2% with no patients requiring re-operation within the early postoperative period. Overall 17.3% went on to have further surgery for their endometriosis although only 3.8% required bowel resection. Patient satisfaction levels were high with a high proportion of patients having symptom improvement post surgery.
Conclusion: The laparoscopic rectal shave is a successful technique for the management of rectovaginal endometriosis with low complication rates and high patient satisfaction. Outcomes are improved by using combined colorectal and gynaecological surgical teams.

P3- A Decade of Fibroid Morcellation at UCLH

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Introduction:
Following recent concerns regarding laparoscopic myomectomy, we investigated the outcomes of patients who had undergone laparoscopic myomectomy at UCLH.
Methods:
A retrospective review of all women who had laparoscopic myomectomy from January 2004 to June 2014 at UCLH.
Results:
250 patients underwent laparoscopic myomectomy. Average number and size of fibroids removed was 1.89 (*1-10*) and 71.2mm (*10-150mm*) respectively. Breach of the uterine cavity occurred in 9.6%. The morcellator was used in 240/250 of cases. Average blood loss was 215ml (*minimal-1500ml*) and 6 cases had blood loss >1000ml. Average post-operative

admission was two nights (*0-7*). Post-operative complications included one wound haematoma, one readmission due to urinary retention and one case of small bowel obstruction. No procedures were converted to laparotomy after attempting laparoscopic myomectomy.
One additional planned laparoscopic myomectomy was converted to laparotomy due to sustaining a bowel injury during initial entry (previous history of bowel surgery during endometriosis treatment). Another patient had a uterine mass inconsistent with a benign fibroid at laparoscopy. The procedure was terminated after biopsy, which later showed a malignant leiomyosarcoma. All morcellated fibroids had benign histology.
Discussion:
In this subject group, morcellation was successful and safe, with no cases of morcellation of malignant tissues.
Conclusion:
In experienced hands, laparoscopic myomectomy appears to be safe and effective. When a fibroid appears suspicious, a biopsy should be taken and histology awaited prior to proceeding. Patient selection should be dependent on co-morbidities, in addition to site, size, number and location of fibroids.

P4- A multi-disciplinary approach to diagnosis & management- Caecal endometriosis versus a Gastrointestinal Stromal Tumour (GIST)

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Endometriosis has an estimated prevalence of 2-10% but this increases to between 10-25% in those presenting with gynaecological symptoms. About 12% of confirmed endometriosis cases are associated with extrapelvic disease, involving structures such as the lower gastrointestinal tract- the most common site being the sigmoid, followed by the rectum, the ileocaecal valve and the appendix.
A 42 year old patient with known endometriosis was managing her symptoms of dysmenorrhoea and non-menstrual pelvic pain with a Gonadotrophin Releasing Hormone (GnRH) agonist and add-back hormone replacement in the form of Tibolone. This had been effective for a duration of three years but a decision was taken for definitive surgery and a laparoscopic bilateral salpingo-oophorectomy was booked.
Concurrently she was under investigation for chronic anaemia and low ferritin. A colonoscopy was undertaken, which demonstrated a 10-12mm smooth sub mucosal lesion arising from the opening of the appendix. The clinical impression was of a possible Gastrointestinal Stromal Tumour (GIST) or carcinoid. The patient was offered a choice between surveillance and surgical excision.
Histological examination of the tissues confirmed endometriosis within the ovarian tissue and the polyp arising from the appendix base. These findings suggest the 'exuberent pedunculate polyp of 0.9cm' may have developed as a result of endometriosis.
Changes in the appearance of the serosal and mucosal surfaces of the large bowel in response to deposits of endometriosis are unpredictable. Therefore, any suspicious gastro-intestinal lesion in patients with endometriosis requires a multi-disciplinary approach to investigation and management to ensure appropriate management.

P5- A new regional anaesthetic block technique for laparoscopic surgery providing enhanced recovery

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Post operative pain control is an important element of promoting rapid recovery and hospital discharge following day case laparascopic surgery. Yet only 60% of patients are satisfied with their analgesia.
Ultrasound guided TAP blocks provides very effective pain relief following laparoscopy. And allow patients to be fit for hospital discharge 25% faster. However, the procedure is highly operator dependant, requires expensive equipment and takes time - So any benefit it offers is negated by getting through fewer patients on an operating list. These drawbacks may explain why its use has never become popular.
A novel technique is described where local anaesthetic agent is placed into the transversus abdominus plane (TAP). This is done under direct vision, when the laparoscope is being introduced with a direct cut down technique. Results of its use show that women having gynaecology laparoscopy as a day case are fit for transfer from theatre recovery to the discharge ward 24% faster (28 mins vs 37 mins. p value 0.03) It is planned to run a randomised trial
It is hoped that as pain is better controlled in the immediate post op phase, this effect will persist and provide more rapid hospital discharge and reduced analgesic demand
There are in excess of 250,000 laparoscopic procedures carried out per annum in the USA. Whilst not all of these are day cases, if this technique allowed patients to be fit for discharge even 20 minutes earlier, there are substantial financial benefits to be made.

P6- A pathway for the management of patients with PMB, once endometrial cancer is excluded

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There are clear management pathways for investigating women who present with postmenopausal bleeding (PMB). The first task is to exclude endometrial and other cancers. However, once this has been accomplished there are no pathways for subsequently managing women. For example, it is not clear at what endometrial thickness women should be offered hysteroscopic examination, and which endometrial polyps, once identified, should be removed. It can be expected that 10 - 20% of women presenting with PMB will have endometrial polyps; others will have recognisable atrophic vaginitis or, by a diagnosis of exclusion supported by features in their history, a resurgence of ovarian activity.
We performed a retrospective review of a cohort of patients who attended with PMB during the first six months of 2014. After excluding women with endometrial and other cancers we collected the following information: endometrial thickness found on (transvaginal) ultrasound scan; findings at hysteroscopy if performed, including the presence of endometrial polyp(s); the histology results of any removed polyps. We developed models to see how many women would be offered hysteroscopy for three given endometrial thicknesses: 5, 7 and 10 mm and for each of these thicknesses how many women would have polyps identified (or missed) and if any unsuspected malignancies were subsequently identified (or potentially missed). This information will help us define what endometrial thickness in our PMB patients should trigger subsequent hysteroscopic investigation, and so enable us to plan our outpatient hysteroscopy sessions and further develop our 'See & Treat' for endometrial polypectomy.

P7- A patient information leaflet for hysteroscopic examination: a proposed generic leaflet

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There is good evidence that patients who receive written information about a procedure prior to attending a hospital appointment experience less anxiety. However, the content of the leaflet is important, as well as how the information is presented, and considerable effort is required when writing such leaflets to ensure that they are comprehensive and can be understood.

Our outpatient hysteroscopy leaflet was due for revision and a new version was produced. However, following last year's BSGE meeting it was apparent from a patient representative that our new leaflet might still not be adequate. For example, it was still insufficiently clear that patients have a choice between outpatient and inpatient examination and investigation, and some of details about the stages in the outpatient investigation were lacking clarity.
We therefore asked for comments from a group of patient representatives about another version of the leaflet and compared ours with those from other units to see if we could develop one that would be more patient-friendly and available to all units providing a hysteroscopy service. The new patient-friendly leaflet will be presented.

P8- A proposal to introduce Cognitive Apprenticeship in Gynaecological Endoscopy Training

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Traditional teaching, especially in technical fields, used the apprenticeship model. Collins et al. in 1991 described the instructional teaching model of Cognitive Apprenticeship (CA), which is a situated teaching model where the expert is required not just to demonstrate the technical (or clinical) procedure, but also to vocalize their thinking, so that the students can learn from their thought process and the various points experience that informed the teacher's decision-making. Thus, CA can be an extremely effective means of training in Gynaecological endoscopy.

CA encompasses 6 key teaching methods:

1. Modelling: the expert shows the students how the task is done, while vocalizing their thought process
2. Coaching: the students perform the task under expert supervision
3. Scaffolding: the expert "fades" as per student needs
4. Articulation: the students articulate their thoughts during performing the task
5. Reflection: the students reflect on the tasks they performed and compare their performance to expert performance
6. Exploration: the students perform tasks independently

A study undertaken by Stalmejer et al has demonstrated that CA is not being used to its full potential in clinical medicine due to shortage of time available to clinical teachers, short placements of students, clinicians while modelling not describing why they were doing what they were doing, clinicians being unaware of the exact stage of student's learning and more emphasis on assessment than feedback. Also, reflection and exploration, though deemed as the 2 most useful components of cognitive apprenticeship, remained largely unused.

P9- A prospective cohort study to investigate the effectiveness of a simulation based structured stepwise approach to diagnostic laparoscopy in gynaecological trainees

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Background: The outcome of the RCOG trainees' survey in 2010 has showed that laparoscopic surgery is one of the top areas of deficiency among gynaecological trainees in the UK. Thus, this 10 step structural stepwise training module was proposed to fulfil training needs in novice trainees in gynaecology.
Aim: To investigate the effectiveness of a simulation based structured stepwise training module on diagnostic laparoscopy in gynaecological trainees in The North East Thames region using box trainers.
Method: This prospective cohort study was proposed to investigate whether the simulation based structural stepwise training module (SSTM) would improve knowledge, skills and perception in gynaecological trainees in the North-East London denary. The impact of SSTM on the trainees were determined using pre and post test score differences between knowledge (MCQs, SEQ), skills (objective and subjective assessments) and perception (reaction evaluation form).
Results: The results demonstrated that the proposed SSTM significantly improved the knowledge and skills in novice gynaecology trainees from ST1-ST3 (p=0.000). The maximum % improvement observed in an individual for of MCQ SEQ, objective and subjective assessment were 45%, 50%, 60.5% and 57.5% respectively. Furthermore, a significant relationship between previous experience in laparoscopic surgery and pre-test scores for skills (p=0.03 for objective pre-test, p=.0.01 for subjective pre-tests) were observed in the trainee cohort. The % improvement of knowledge or skills after simulation were not related to the demographic factors (P>0.05).
Conclusion: Based on above results, this study concluded that proposed SSTM is an effective tool for laparoscopic simulation in novice trainees.

P10- A rare and unusual necrotising fasciitis with E.Coli as complication of laparoscopy

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Necrotising fasciitis is a rare and potentially fatal infection characterised by rapid and progressive involvement of the fascia and subcutaneous tissue. Early diagnosis and appropriate debridement of the infected tissues, with aggressive antibiotics therapy, remains the mainstay of the treatment. This is the case of a 22 year old lady who underwent a straight forward diagnostic laparoscopy for chronic pelvic pain, during which, no cause for her pain was identified. It was an uneventful procedure but this was shortly followed by an overwhelming necrotising fasciitis of the anterior abdominal wall from the suprapubic port insertion. A subsequent CSU culture indicated that she probably had an asymptomatic coliform UTI at that time. Intraoperatively, there was a 'through and through' injury to the bladder, presumably by the Veress needle insertion, which extravasated infected urine around the subcutaneous tissue of the anterior abdominal wall, bladder and peritoneal cavity. Her condition was extremely poor but she was managed appropriately by surgical debridement and antibiotics and thus escaped a catastrophic event.

P11- A rare case of acute non-puerperal uterine inversion managed by laparoscopically-assisted vaginal hysterectomy

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Aim
To highlight a rare cause of severe abdominal pain and vaginal bleeding, and describe a laparoscopic approach to managing non-puerperal uterine inversion.
Case Report:
A 47-year-old nulliparous female presented to the emergency department with sudden onset, severe abdominal pain and vaginal bleeding. Her history included menorrhagia and 2cm fundal fibroid. She was pale and vomiting with severe pain despite 20mg of intravenous morphine. On examination, her abdomen was firm and her uterus impalpable. A round, broad-based mass lay within the introitus, acting as bung to profuse vaginal bleeding. An expelled Mirena coil lay posteriorly. An extruded fibroid polyp or uterine inversion was suspected.
In theatre, vaginal examination revealed almost complete inversion of the uterus with a fundal fibroid attached. On laparoscopic entry, the uterus was found to have formed a funnel into which the fundus, corpus,

fallopian tubes and round ligaments had retracted. After a successful laparoscopically-assisted vaginal hysterectomy, the patient was discharged well the following day.

Conclusion

Acute non-puerperal uterine inversion is rare with fewer than 150 cases reported until 2006. It should be suspected in women with sudden onset pain and bleeding, an impalpable uterus and a vaginal mass. We have found only one other report of non-puerperal uterine inversion managed by laparoscopically-assisted vaginal hysterectomy1. The procedure is complicated by the distortion of the pelvic anatomy resulting from uterine inversion, with the ureters being brought into close proximity of the ovarian and uterine vessels by traction on the vascular pedicles.

P12- A retrospective descriptive comparison study of transvaginal ultrasound scan findings with hysteroscopy and histology findings on postmenopausal women who underwent hysteroscopy for postmenopausal bleeding

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Objective:

To define an endometrial thickness, that helps to identify postmenopausal women with a high risk of having an endometrial polyp.

To bring clinical effectiveness in investigation for postmenopausal bleeding

Design: Retrospective descriptive study. Outcomes were compared with histology outcomes.

Population: postmenopausal women who underwent a transvaginal scan followed by hysteroscopy within 28 days of the scan over a two year period (390 cases)

Results: 143 (37%) women had ultrasound findings suggestive of an endometrial polyp and 140 (36%) had a thickened endometrium but no evidence of an endometrial polyp on USS. The remaining 107 cases (27%) had inconclusive USS findings, and an endometrial polyp could not be excluded.

When a scan was suggestive of an endometrial polyp in postmenopausal women, the positive predictive value of a polyp in histology was 82%.

When a scan was not suggestive of an endometrial polyp (140), 41% (57/ 140) had no polyps but 59% (83/140) had polyps on histology.

Mantel-Haenszel common odds ratio estimate shows that the statistical significance of the risk of having an endometrial polyp is higher when the endometrial thickness is 9mm and above compared to if the endometrial thickness is 8 mm or below.

Conclusion: Difference in detection rate of endometrial abnormality and polyps in patients with postmenopausal bleeding shown ineffectiveness in present clinical pathways.

For a protocol to decide the need of operative hysteroscopy or hysteroscopy under general anaesthesia, for postmenopausal women, an endometrial thickness of 8 mm cut off can be used.

P13- A story of a patient and her ovarian monsters

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Background: Mature ovarian teratomas account for 10-20% of all ovarian tumours and are most common in women aged 20-40 years. It is reported that 8-15% occur bilaterally and recur in just 4.2% of cases following surgical excision.

Case Presentation: We report a case of a 39 year old nulliparous female who has had six operations over the last 17 years to excise a total of 19 ovarian dermoid cysts that recurred bilaterally. Her first two initial ovarian cystectomies were performed by laparotomy whilst the last four procedures were laparoscopic. During all laparoscopic procedures, there was no spillage of cyst contents into the abdomen or pelvis and the dermoids were all removed using an endocatch bag. There were no residual cysts left behind at the end of each operation.

Discussion: There is little in the literature about why ovarian teratomas recur after surgical excision and what steps can be taken to prevent this. It has been suggested that recurrence of ovarian teratomas are more frequent following laparoscopy as opposed to laparotomy. However, this case demonstrates that dermoid cysts can recur after laparotomy and perhaps with the advantages of minimally invasive procedures, such as swifter post operative recovery, laparoscopy should prevail as the gold standard.

P14-Acceptability of Out-patient Hysteroscopy procedures

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Aim: To assess patient tolerance to hysteroscopic procedures at the ambulatory Gynaecology clinic at Queen Alexandra Hospital, Portsmouth.

Materials and Methods: Data was collected prospectively over a two year period from January 2013 to December 2014. Primary outcome was pain score on a 10-point visual analogue score at the beginning, mid proceure, on completion and in recovery. We also looked at the additional analgesia requirements post procedure and complication rate. The data was analysed using SPSS.

Results: A total of 61 procedures were performed. Essure sterilisation (26.2%), Myosure polypectomy (23%) and Endometrial ablation procedures - Novasure (21.3%); Minitouch ablation (16.4%) and Hydrothermal ablation (13.1%). Median Visual analogue score mid procedure was highest for Novasure(7). (whisker plot attached). However, in recover the Median visual analogue score dropped down to 2 for all procedure except HTA with a VAS of 1. Only 4 (6.5%) patients required additional analgesia in recovery and 2 (3.2%) patients had a vasovagal episode.

Conclusion: Essure, Myosure and endometrial ablation procedures are well tolerated by patients in the Out patient settings with low procedure related complications. Novasure has the hightest mid procedure visual analogue score but in recovery all patients reported a low pain score.

P15- An audit of the adherence to the 2 week wait referral pathway for patients with Post-Menopausal Bleeding

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Aim To assess referrals of patients with postmenopausal bleeding are compliant with National cancer care pathway guidelines and to improve compliance with standards, as well as improve clinical efficiency and patient experience.

Methodology Retrospective audit on patients identified from 2 week wait referrals made to the Ultrasound department between July 2013 and April 2014. 138 patients were identified and data obtained.

Results Women with endometrial thickness <4mm were appropriately discharged in 80% of the cases. Of the 96 patients seen in Gynae outpatient department 19% were not examined. The pipelle biopsy was successfully obtained in 61% with most common cause of failed procedure being cervical stenosis. Endometrial carcinoma was identified in 6

patients accounting for 10% of those who underwent hysteroscopy. The target of 14 days was met in 58% of patients.

Discussion Dedicated ultrasound supported PMB clinics will be useful as 80% of the cases were appropriately discharged reducing the work load to the GOPD.

One-stop PMB clinics where USS, examination and biopsy can all be performed in succession, improves patient experience and reduces waiting time. It is reasonable to suggest that biopsy should be attempted in all patients in GOPD unless the patient opts out. Women with cervical stenosis should be referred to OPH to have the option for the procedure under local anaesthesia. Patients unable to tolerate speculum examination could be referred to out-patient hysteroscopy for vaginoscopy to avoid general anaesthesia where possible.

Implementation of a guideline with a flowchart followed by re-audit would be valuable.

P16- An investigation into laparoscopic entry technique preference amongst UK Surgeons and Gynaecologists - Assessment of the best practice and future training

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Although laparoscopic surgery is now practiced commonly as a first choice over open surgery, its major complications have not changed in the last 25 years. At least 50% of its major complications happen during access, and therefore worryingly even before commencement of the intended procedure. We carried out a comprehensive survey of over 150 UK Surgeons and Gynaecologists with the aim of investigating influences in the practice of different entry techniques. This included training, attitude to change and willingness to address any training issues. Our results highlight interesting trends in practice. Perhaps this is the first study where Surgeons and Gynaecologists are questioned simultaneously. 78% of our respondents were Consultants, 70% of them practicing over 10 years and 40% over 20 years clinical situation, over 50% had not changed their practice from what they were trained in. justify the views of this study from established doctors. Most of the gynaecologists indicated a preference for closed entry surgery whilst majority of our 38 general surgical respondents preferred open entry technique. This variance was mostly due to the way these senior practitioners were trained. Although 85% believe that methods of entry should be changed according to the patient's Despite a heartening 94% were in agreement that different methods of training should be made available, our study also indicates that an opposition to change is present in laparoscopy and should be addressed. We suggest that the curriculum of training in both these surgical specialties should be broadened to include wider training opportunities.

P17- An unusual cause of chronic pelvic pain: Pseudomyxoma Peritonei

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A 35 year old, para two, presented to the gynaecology department with a two year history of increasing suprapubic pain. It intensified mid-cycle and five days prior to her period. She complained of significant menorrhagia, dysmenorrhoea, deep dyspareunia and dyschezia.

At laparoscopy copious amounts of mucoid exudate was seen occupying the uterovesical fossa and surrounding both ovaries. Her uterus, fallopian tubes and ovaries appeared normal and there was no evidence of endometriosis. An inflammatory exudate was seen along peritoneal surfaces of the anterior abdominal wall with obvious adhesions on both lobes of the liver. The appendix appeared normal. A sample of the mucoid fluid was sent for microscopy and culture and the patient was treated for presumed pelvic inflammatory disease.

The infection screen was negative and the fluid showed pus cells with no bacterial growth. Her symptoms did not improve and she was therefore referred to a national specialist centre with a possible diagnosis of pseudomyxoma peritonei. Further investigations including CT scan, colonoscopy and repeat laparoscopy, confirmed the diagnosis of a perforated mucinous appendiceal tumour. She underwent complete cytoreduction with pelvic clearance, appendicectomy, splenectomy, cholecystectomy and omentectomy. All peritoneal surfaces were stripped including the diaphragms and liver capsule followed by heated intraperitoneal chemotherapy (HIPEC).

Although pseudomyxoma peritonei is a rare condition affecting one person per million per year, any surgeon operating within the abdomen may occasionally encounter this borderline malignant, slowly progressing tumour which has poor long-term survival rates of 10-30% over 10 years if untreated.

P18- Application of the principles of higher education to laparoscopic training

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As we enter the golden era of gynaecological endoscopy, training future generations to provide high quality patient centred care gains paramount importance. In my review, I discuss how the theories of learning in higher education can be applied to laparoscopic training.

Firstly, I discuss, the need to develop an outcome-based spiral curriculum (in accordance with Biggs) for gynaecological endoscopy (GE), which is constructively aligned with the teaching delivered and the assessments used with an aim to facilitate the development of a holistically trained laparoscopic surgeon.

I elaborate on my proposal under the following subheadings:

1. Intended learning outcomes including development of specialist knowledge, organizational skills, intellectual skills and personal attributes.
2. Learning in GE: to promote a deeper approach to learning – to ensure that the students Remember, Understand and Apply well (as per Anderson et al.'s update to Bloom's taxonomy) and also spend considerable time Analyzing, Evaluating and Creating.
3. Teaching in GE to include cognitive apprenticeship, integrated longitudinal clerkship, peer controlled teaching, collaborative exercises and self-reflection.
4. Assessment of learning outcomes: Based on the work of Rust, I propose a wide variety of assessments spread throughout the year with emphasis on formative assessment and timely constructive feedback.
5. Evaluation of training provided: Trainees be encouraged to provide confidential training feedback to the BSGE on the adequacy of the curriculum, training methods and the assessments

These measures would hopefully enhance higher order thinking with appreciation of the principles of caring and the human dimension.

P19- Are we counseling patients correctly prior to Endometrial Ablations?

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Background:

Despite following NICE guidance[2007] promoting Mirena/Ablation for heavy periods we noted that our hysterectomy rates had not decreased.

Objectives:
To investigate further intervention rates post second generation endometrial ablation.
Design:
We undertook a retrospective study looking at patients undergoing endometrial ablation procedures and their satisfaction/further intervention rates
A surgical coding report was produced containing patients undergoing an ablation procedure between January 2008 and December 2012 (5 years)
All 682 patients were contact via mail and asked to complete a survey, 287 responded.
Results:
64% of patients were satisfied with the outcome of procedure (i.e. symptom relief)
of this group 12% still required further treatment.
Of ALL patients 39.5% required further treatments
52% of Patients who failed to be satisfied with ablation and had previously failed with a mirena coil went on to require further treatment, much higher than the 22% of the group previously successful treatment with a mirena .
It is interesting that in the previous failure with Mirena group 34% went on to have a hysterectomy compared to none of those previous successful with a mirena..
Discussion:
Ablations are now in widespread use and perhaps we are using it above its limitations - meaning a higher failure with more difficult cases
Patients who have previously failed to be successfully treated with a mirena coil are at a higher chance of having a failed ablation procedure
More specifically a higher risk of Hysterectomy
If these patients were told of their increased further intervention risks they choose an ablation?

P20- Asherman syndrome

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The outcomes of Asherman's syndrome after surgical correction have a wide variation in reported outcomes in terms of menses, conception and complications in pregnancy. The challenges and possible variables affecting the outcomes of hysteroscopic adhesiolysis is discussed in the context of 2 cases that went on to achieve ongoing pregnancy. In the first case, pregnancy was achieved after 4 months. Pregnancy was complicated by abruption requiring emergency caesarean section at 34 weeks and severe haemorrhage.The second patient is 31 weeks in an ongoing pregnancy.
In both cases the endometrial cavity was obliterated by adhesions. Neither tubal ostia were reached. Hysteroscopic location the adhesiolysis was confirmed by concurrent trans-abdominal ultrasound guidance. First case: The cavity was essentially normalised though the endometrium appeared denuded. Second case: 3D ultrasound gave the appearance of a subseptated uterus reaching down to the cervix. At hysteroscopy the septum had the hallmark appearance of fibrotic scar. Both tubal ostia were identified through a narrowed passage from the cervix to each tubal ostium on each side. The adhesions between the two were divided using a twizzle via a 0 degree angulated 4mm versascope (Gynaecare). In both cases a copper IUS was placed for 6 weeks. Both patients received 28 days of ethyl-oestradiol.
We propose an audit tool for Asherman's syndrome that could be used by clinicians to audit their outcomes, and if endorsed by the society could provide a reflection of the UK experience of the incidence, severity, management and outcome of this condition.

P21- Atypical polypoid adenomyomas

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Atypical polypoid adenomyomas (APA) are rare tumours of uterine corpus, usually occurs in premenopausal group, presents with abnormal uterine bleeding. APAs are classified as benign mixed epithelial and mesenchymal tumour, was first described by Mazur in 1981.
The histology features are very similar to well differentiated endometrial carcinoma, in some cases it is difficult to distinguish between APA and endometrial cancer.
Even though APA is categorised as a benign lesion, recurrence or residual primary lesion has been reported to occur in 30.1% of cases that were managed conservatively. Moreover, endometrial carcinoma is detected in 8.8% of APA cases.
There have been cases reported with coexisting carcinoma or cases, which have progressed to carcinoma. Thus follow up is crucial in management of these cases.
We present a case of atypical polypoid adenomyoma, which was diagnosed after hysteroscopy and polypectomy prior to IVF treatment.

P22- Audit of 23 women diagnosed with miscarriage who attended University Hospital South Manchester Early Pregnancy Unit over a 3 month period

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Approximately 20% of clinical pregnancies end in miscarriage. The aim of this audit was to compare current practice with National Guidelines. Women attended the Early Pregnancy Unit between October and December 2014. Their ages ranged between 22 to 41 years of age. Parity ranged between Para 0 to Para 5. 22%(5/23) had a previous miscarriage and 13%(3/23) had a previous termination. 42%(8/23) were referred by their General Practitioner and 32%(6/23) from the Accident and Emergency Department. 43%(10/23) presented with abdominal pain and vaginal bleeding, 39%(9/23) with vaginal bleeding alone. The majority of women required 2 ultrasound scans for their diagnosis. 57%(13/23) were diagnosed with missed miscarriage and 43%(10/23) with incomplete miscarriage. Bloods were taken in 100%(23/23) of cases. 4%(1/23) required emergency admission for heavy vaginal bleeding. In women who chose expectant management, 75%(6/8) were successful. 25%(2/8) proceeded to medical management with 100%(2/2) success rate. In women who chose medical management, 67%(4/6) were successful. 33%(2/6) proceeded to surgical management with 100%(2/2) success rate. Their length of admission ranged from 22 to 62 hours. In women who chose surgical management, 100%(6/6) were successful. Their length of admission ranged from 6 to 9 hours. All women had consent forms completed and Anti-D administered if appropriate. Patient choice is paramount and psychological sequelae common, thus patients should have access to support and counselling. Alternative methods are becoming more widely available which help reduce length of hospital admission and improve patient quality of life. These include outpatient medical management and manual vacuum aspiration.

P23- Bowel Herniation into Pre-peritoneal Space in a 5mm port site

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A 45 year old G3 P3 with BMI 25 underwent a total laparoscopic hysterectomy with bilateral salpingo-oophorectomy for fibroid uterus and menorrhagia.

The procedure used 4 non-dilating ports (10, 5,5,5mm), a 20 French Robinson drain was inserted into left lateral 5mm port at closure. Other port sites were closed with Prolene.
The following day, the patient complained of localized lower abdominal pain 4 hours after drain was removed and a mass developed gradually at the port site. A presumed diagnosis of port side bowel herniation was confirmed by CT imaging showed a small bowel hernia associated with bowel obstruction.
Laparoscopy revealed mid-small bowel incarcerated hernia within the pre peritoneal space which was reduced laparoscopically. The patient made an uneventful recovery.
This case highlights the rare but known risk of herniation through a 5mm port after removal of drain[1]. Current RCOG guidelines suggest all lateral ports of less than 10mm do not need closure. The musculature of the abdominal wall that underlies the fascia and the fascia elasticity will normal prevent herniation[2]
A systematic review has found that slowly absorbable and non-absorbable sutures reduce risk.[3]There is evidence to suggest that a non traumatic, bladeless trochars in reducing risk of hernia.[4]
Diabetes, smoking, excessive manipulation of trocar and lower quadrant ports due to absence of posterior sheath may increase the risk. [5]Elderly patients and thin patients also have a reduced strength and elasticity of fascia so may be more prone to hernia[2].

P24- Carboprost: A Useful Adjunct in the Laparoscopic Resection of a Cornual Ectopic Pregancy

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Introduction
Cornual ectopic pregnancies are a rare, but very challenging form of ectopic to manage. Laparoscopic resection can be a successful fertility preserving treatment option, but there is always a high risk of haemorrhage/hysterectomy. We present the first case of its kind where intramyometrial carboprost injection was used successfully, prior to laparoscopic resection, to help delineate the ectopic, improve visualisation, aid resection and reduce potential blood loss in a challenging case.
Case Report
A 38-year-old woman presented to the EPU at 6-weeks pregnant with abdominal discomfort. A right cornual ectopic was diagnosed on scan and subsequently managed surgically. In theatre, the findings were a diffuse enlargement of the cornua with no discrete ectopic visible making attempted resection technically difficult and potentially hazardous. 500mcg carboprost was injected laparoscopically directly into the myometrium surrounding the ectopic. This resulted in localised myometrial contractions, pushing the trophoblastic tissue closer to the uterine surface and demarcating it more clearly for resection. Monopolar diathermy was used to make an incision over the ectopic and suction used to remove the POC. The incision was sutured laparoscopically and blood loss was <50mls. She was discharged home the following day and completely discharged 2 weeks later with a negative βHCG.
Conclusion
Cornual ectopic pregnancies remain a challenging clinical dilemma. Laparoscopic resection is a safe treatment option and the use of intramyometrial carboprost injection prior to resection appears to improve visualisation and delineation of the ectopic pregnancy, resulting in a technically more straightforward resection with significantly reduced blood loss.

P25- Case Report - Laparoscopic management of a 20cm ovarian cyst in the third trimester of pregnancy using direct optical entry as an alternative approach

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Introduction
The prevalence of ovarian cysts in pregnancy is reported as between 1-2%. The decision to operate in pregnancy is difficult with views on optimal management and timing of surgery being controversial.
Case Report
A 20-year-old primiparous woman presented with a 16x11x20cm multi-septated right adnexal cyst, identified at first trimester ultrasound. She had a past medical history polycystic ovarian syndrome and a BMI of 44. Tumour markers were normal. Conservative management with regular monitoring was agreed.
Following an acute admission with abdominal pain the patient underwent ultrasound-guided aspiration of the cyst at 23/40. Cytology showed no malignant cells. The patient had recurrent admissions with acute pain from 27-30 weeks gestation, managed conservatively due to risk of mid-line laparotomy, preterm labour and prematurity. USS confirmed re-accumulation of the cyst. The aim was for caesarean delivery by 32-34 weeks with right ovarian cystectomy/oophorectomy. At 30+4 weeks-gestation the decision was made for surgery in view of non-resolving symptoms and suspicion of torsion. The patient underwent laparoscopy via direct optical entry to the right-side of the abdomen with planned insertion into the ovarian cyst capsule. The ovarian vessels were identified, demonstrating evidence of multiple torsion. The patient underwent right salpingo-oophorectomy. A small grid-iron incision was made to remove the enlarged complex cyst. Histology confirmed ischaemic necrosis.
Discussion
We present this case report with contemporary review of the literature. We describe our laparoscopic approach as a safe alternative in the management of large ovarian cysts in advanced pregnancy.
1. Zanetta et al. BJOG 2003; 110:578-583.

P26- Case Series of Different Management of Caesarean Section Scar Pregnancy

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Case1:
1st case was in her third pregnancy diagnosed at 7 weeks gestation when she presented with vaginal bleeding. Gestational sac was seen implanted at CS scar away from uterine cavity.
She was counselled o have systemic and local MTX. Dose calculation at 1mg/m2 and also next day she was given transvaginal ultrasound guided using double lumen egg collection needle. Initially sac content was aspirated then 1 ml KCL was injected till cessation of fetal heart activity. Then 40mg MTX was injected into the sac.
HCG follow up showed gradual decline till negative in 6 weeks.
Case 2:
The second case was 33 years old previous 1 CS. In this case we gave her systemic MTX only at 1mg/m2. Her initial response was good with decline of HCG by 60% over one week but plateau in the second week at 600 IU and 55IU. The sac was getting bigger, more vascular on Doppler.
Decision was to proceed with surgery in view of the size of the mass and plateuing HCG. We decided on vaginal approach with ultrasound guided surgical/suction evacuation. The procedure was started with a Shirodkar suture that acted as a tamponade to control any operative bleeding. The procedure continued by suction evacuation under ultrasound guidance. She stayed inpatient and suture was removed in 48 hours. Her HCG decline was steeper and became negative in 3 weeks.
Case 3:
This patient was managed by Ultrasound guided suction evacuation without the use of Methotrexate. Her HCG decline was satisfactory.

P27- Comparing laparoscopic and open surgical management of all endometrial cancer patients in the North West Thames Gynaecological Cancer Network

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BACKGROUND: Endometrial cancer is the fourth most common malignancy in women in the UK. NICE guidelines state that there is sufficient data on safety and efficacy to support the use of laparascopic total hysterectomy and laparoscopic assisted vaginal hysterectomy for the treatment of endometrial cancer.
METHOD: A retrospective audit was compiled looking at all women treated for endometrial cancer in the North West Thames Gynaecological Cancer Network from 1st April 2012 to 30th September 2012.
RESULTS: 62 women were identified as having had surgical treatment for endometrial cancer. 76% of cases were managed in a tertiary cancer unit and 71% of cases were completed laparoscopically. Many of the patients were obese (average BMI 32) and 66% of cases had stage 1A disease. Patients having a laparoscopic procedure stayed in hospital for a significantly shorter time than those who had an open procedure. Two laparoscopic procedures were converted to an open operation but there were a greater number of post-operative complications in those having open surgery. 45% of patients did not require any adjunctive treatment.
CONCLUSION: Despite the growing problem of obesity, the majority of patients still present with early stage disease. Most patients were operated on by a laparoscopic approach. These patients had fewer complications rates and were able to be discharged more quickly. Confirming that laparoscopic procedures are a safe and affective way of treating endometrial cancer.

P28- Comparing MRI and laparoscopic results of patients in an endometriosis MDT

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Background and Aim
MRI has been shown to be an accurate and a cost-effective tool for the preoperative staging of deeply infiltrating endometriosis (DIE). Pennine Acute Hospitals NHS Trust is a recognised endometriosis centre. An MDT was established in March 2014 to aid management of the condition. This MDT includes gynaecologists, radiologists, urologists, and colorectal surgeons. The severity of disease can be assessed on diagnostic laparoscopy. However MRI is a non-invasive tool that can help women in making a choice of different treatment options. The aim of our retrospective quality improvement project was to compare preoperative MRI findings and diagnostic laparoscopic results.
Methodology
Fourty-five patients were included in an endometriosis MDT between 07/04/14 and 03/01/15. Thirty-six patients who had DIE on MRI were included in the study. MRI findings, MDT results, histology results and laparoscopic findings were collected for these patients. These were tabulated and analysed using Microsoft Excel.
Results
Twenty-five out of the 36 patients had surgery, 6 chose medical treatment and 5 are awaiting surgery. Furthermore, due to the MDT a patient was identified as having diverticular disease and not endometriosis. Overall, approximately 80% of MRI findings correlated with laparoscopic findings. Specifically, this was 92% for bladder endometriosis, 76% for recto-vaginal, 64% for rectal, 80% each for left and right endometrioma; and 83% for bilateral endometriomas.
Discussion and Conclusions
MRI is beneficial for localising and mapping DIE. It helps plan MDT approaches to surgical management and helps women to make an informed choice.

P29- Complications and Length of Hospital Stay following Total Laparoscopic Hysterectomy: Support for Daycase Laparoscopic Hysterectomy

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Background:
Laparoscopic hysterectomy has proved a cost saving and viable alternative to a total abdominal hysterectomy or a vaginal hysterectomy. Day case total laparoscopic hysterectomies are already being performed and these could lead to even further cost reduction due to the decreased hospital stay. However this needs to be evaluated carefully to ensure that patient's risk of post operative complications are not increased. Here we look at a small cohort of women who have undergone a total laparoscopic hysterectomy as an inpatient to evaluate whether this supports day case hysterectomies.
Aim:
To evaluate the complications, length of hospital stay and patient satisfaction after total laparoscopic hysterectomy in a district general hospital in order to provide support to the possibility of outpatient (day case) laparoscopic hysterectomy
Methods:
A retrospective analysis of 64 women who had undergone a total laparoscopic hysterectomy in a district general hospital.
Results:
Of the 64 women booked for total laparoscopic hysterectomy, there were no major intra-operative or immediate post-operative complications. The average haemoglobin drop was 1.75 g/dL. The median hospital stay was 2.5 days (one of these being pre-admission) and the median period of recovery to normal activity was 3.5 weeks.
Conclusion:
The low rates of complications, minimal blood loss coupled with the already short hospital stays (the average length of stay post procedure was 1.5 days) suggest that total laparoscopic hysterectomy as a day case is a safe, viable and potentially cost saving procedure for a large number of patients.

P30- Correlation of MRI findings with findings at laparoscopic surgery

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Our study going back 5 years looks at how MRI reports have correlated with actual findings at laparoscopic surgery. We discuss when differences have occured, its impact on patient management.

P31- Documentation of Laparoscopic procedures. How good are we at completing operative notes and discharge summaries?

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Accurate and legible documentation are prerequisites for delivering high-quality care.
Almost 250,000 woman undergo Laparosopic surgery yearly. Articles on safety entry techniques and operating are established, therefore every effort should be made to include these techniques on operation notes. In addition to

this, most laparoscopic day cases are discharged back to GPs, and with NHS England stating that 33% of hand written and 26% of electronic discharge summaries fell short of NICEs minimum standards for clinical communication, it is vital to ensure discharge summaries are clear and accurate.
Given this, an audit was performed to determine how well we documented our operative procedures and how accurate our discharge summaries were.
A prospective audit was completed which include 50 sets of notes.
Results: 90% of primary operating surgeon completed notes. 50% of attempts of veress entry were documented. Palmers test documented in 10%. Starting intraabdominal pressure documented in 72%. Reduction of pressure after trocar insertion documented in 34% of cases. 86% of operation notes were clearly documented. Suture material used for skin documented in 94%. Of those discharged back to GP, 80% had clear discharge summaries.
Results showed areas that can be improved on in terms of documentation, and we have devised a sticker that can used on operating notes to help document key steps. Other recommendations include computerised documentation.
The discharge summary can be improved by ensuring a registrar or consultant reviews this, as this is usually left up to the most junior member of the team to complete.

P32- Does the addition of bilateral salpingectomy (BS) at laparoscopic hysterectomy increase morbidity?

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Background: Recent evidence suggests the fallopian tubes may be the origin of certain serous ovarian cancers. Post-hysterectomy the fallopian tubes are redundant and can cause hydrosalpinx, pelvic pain and ectopic pregnancy. Increasingly more women are undergoing prophylactic BS and studies demonstrate that BS does not affect ovarian function. However, does it affect short-term morbidity?
Objective: To assess whether BS at total laparoscopic hysterectomy (TLH) or laparoscopic subtotal hysterectomy (LASH) influenced surgical time, blood loss or length of hospital stay.
Method: A retrospective case-control study. The cohort consisted of 306 consecutive single surgeon laparoscopic hysterectomies in a London hospital. BS or bilateral salpingo-oophorectomy (BSO) was used selectively. Results were analysed using the Student t-test and Mann-Whitney test. Significance was a p-value of <0.05.
Results: 57 out of 112 (51%) had a TLH, 21 (19%) had a TLH-BS and 34 (30%) had a TLH-BSO.
117 out of 194 (60%) had a LASH, 50 (26%) had a LASH-BS and 27 (14%) had a LASH-BSO.
LASH-BS was significantly associated with lower blood loss and shorter length of hospital stay compared to LASH alone or LASH-BSO. TLH-BS was significantly associated with lower blood loss compared to TLH alone or TLH-BSO, and significantly shorter surgical time compared to TLH-BSO.
Conclusion: We conclude that the addition of BS at laparoscopic hysterectomy is not associated with short-term morbidity. Lower blood loss may reflect the surgeon learning curve. This bolsters evidence that women should consider BS at laparoscopic hysterectomy and this information can be used during informed consent.

P33- Encephalitis associated with dermoid cyst - case report and review of literature

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Case presentation:
A 29 year-old office worker presented to hospital with history of headache, pyrexia, aggressive behaviour and hallucinations.
Her past history included depression treated with Sertraline, which was discontinued one week prior to admission.
Gradually she became obtunded with dystonic attacks and developed seizures.
Her condition deteriorated further requiring ICU care and intubation.
After several investigations she was diagnosed with autoimmune encephalitis.
CT pelvis showed 14 mm ovarian dermoid cyst.
Anti-NMDA encephalitis was suspected and decision was made for oophorectomy.
NMDA receptor antibody was negative in serum but positive in cerebrospinal fluid.
She has been making gradual clinical recovery.
Discussion:
The N-methyl-D-aspartate receptor (NMDA) is involved in normal physiological and pathological states in the brain.
Anti-NMDA encephalitis is characterized by memory deficits, seizures, confusion, and psychological disturbances in males and females of all ages. This type of encephalitis is often associated with ovarian teratoma in young women.
Treatment includes immunotherapy e.g. high-dose intravenous corticosteroids, immunoglobulins, plasma exchange, cyclophosphamide, azathioprine, mycophenolate mofetil, tacrolimus, methotrexate, and monoclonal antibodies (e.g., rituximab) in sequence or in combination. Some patients may recover to their normal state with supportive care alone. Most of the patients required further treatments such as tumor resection and immunotherapy. It has been proposed that the tumour should be removed when present.
Recovery may take 2 years or longer, and the patient may not always return to their former levels of motor function and cognition. Prognosis is better after tumor resection and immunotherapy.

P34- Endometrial ablation using radiofrequency in women with previous Caesarean Section: is this a safe procedure?

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Introduction:
The device used radiofrequency for endometrial ablation (NovaSure®). The machine switches itself off when the impediance is too high.
Aim:
Does the device perform safely in cases with previous Caesarean Sections if the thickness of the scar is unknown?
Method:
Prospective safety audit between March 2011 and August 2014. Most women had an ultrasound but the caesarean section scar was only mentioned once. All women undergone a hysteroscopy before insertion of the device.
Results:
94 patients were listed for endometrial ablation. In eleven cases endometrial ablation was not attempted as there were unexpected clinical findings at the time of the diagnostic hysteroscopy.
83 cases undergone endometrial ablation.
In four cases (5%) endometrial ablation device was introduced but the procedure was abandoned by the machine: one case had large fibroid, one case cavity was probably too wide, one case a possible instrument failure. One case had a very thin lower segment as documented on pre-op scan (one case out of the 20 cases with previous caesarean section 5%).
79 patients had endometrial ablation performed. Out of those 19 cases had previous LSCS: 6 cases had one previous LSCS, 3 cases had two previous

LSCS, 8 cases had three previous LSCS, one case had four previous LSCS. One case had a history of uterine perforation.
There was no acute complication.

P35- Endometriosis care pathway and the role of an Endometriosis Specialist Nurse

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The role of an Endometriosis specialist nurse (ESN) varies from centre to centre and within each centre, the role will evolve over time with experience. In this poster, we share our experience in setting up a post for a new ESN and the effects this has had on our service provision. We explore various duties and responsibilities of the ESN and also share our integrated endometriosis care pathway for the benefit of other developing centres.
Our ESN started in the year 2014. Her job was initially funded by the innovation fund and later her salary was paid by the income generated by her clinics.
Following duties are performed by our ESN:
Triage and co-ordinatation of care between teams and with GPs
Educating junior doctors and nurses
Collating and entering data into the BSGE database
Running patient support groups and follow-up clinics
Managing and updating the website, patient information leaflets and care pathways
Telephone follow-up
Providing direct telephone access for patients
Counselling and supporting patients throughout their treatment journey
Supporting ward nurses in caring for patients who had complex surgeries
Contributing to audit and research
The ESN has proven to be an invaluable asset to our centre

P36- Essure hysteroscopic sterilisation : Compliance with NICE guidance, our experience

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Essure hysteroscopic sterilisation is minimally invasive outpatient method of female sterilisation.
This method has many advantages including no incision, high successful bilateral placement rates, non-mandatory use of anesthesia, out patient procedure, Low level of pain, and low risk surgery. Therefore it is highly recommended than traditional laparoscopic sterilisation, which has more serious complications.
This type of sterilisation is particularly useful in patients with high BMI, with multiple previous abdominal surgeries.
The Essure system consists of two microinserts comprising a dynamic outer coil and an inner flexible coil, which are placed hysteroscopically into the fallopian tubes under direct vision.
Essure hysteroscopic sterilisation was performed in Outpatient procedure clinic, University hospital of Wales.
We present successful placement rates, pain scores during the procedure and outcomes at 3 month follow up.
It is a safe, quick, effective and irreversible method of sterilisation.

P37- A new regional anaesthetic block technique for laparoscopic surgery providing enhanced recovery

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Post operative pain control is an important element of promoting rapid recovery and hospital discharge following day case laparascopic surgery. Yet only 60% of patients are satisfied with their analgesia.
Ultrasound guided TAP blocks provides very effective pain relief following laparoscopy. And allow patients to be fit for hospital discharge 25% faster. However, the procedure is highly operator dependant, requires expensive equipment and takes time - So any benefit it offers is negated by getting through fewer patients on an operating list. These drawbacks may explain why its use has never become popular.
A novel technique is described where local anaesthetic agent is placed into the transversus abdominus plane (TAP). This is done under direct vision, when the laparoscope is being introduced with a direct cut down technique. Results of its use show that women having gynaecology laparoscopy as a day case are fit for transfer from theatre recovery to the discharge ward 24% faster (28 mins vs 37 mins. p value 0.03) It is planned to run a randomised trial
It is hoped that as pain is better controlled in the immediate post op phase, this effect will persist and provide more rapid hospital discharge and reduced analgesic demand
There are in excess of 250,000 laparoscopic procedures carried out per annum in the USA. Whilst not all of these are day cases, if this technique allowed patients to be fit for discharge even 20 minutes earlier, there are substantial financial benefits to be made.

P38- Evaluation of the 2-week referral system for urgent investigation of postmenopausal bleeding in a District General Hospital setting Maria Boland MBBS BSc , Mark Broadbent BSc MFFP FRCOG

Maria Boland[1*], Mark Broadbent[1,2]
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Aim: To investigate the incidence of endometrial carcinoma in patients screened according to the NHS 2-week target for postmenopausal bleeding.
Methods: Cross-sectional study undertaken at one NHS District General Hospital. Retrospective analysis of all patients presenting to our Gynaecology department under the 2-week referral pathway over one year. Hysteroscopy was offered to patients with endometrial thickness of greater than 5mm on TVUSS. Ultrasound findings, hysteroscopy findings, and histology results were correlated with clinical history to determine the incidence of endometrial carcinoma. Inclusion criterion was postmenopausal bleeding. Multips and primips were included. Women on hormonal treatment were excluded from the study.
Results: 107 referrals were received during this period. The mean age was 72 (range=50 – 86). 51 women (48%) underwent biopsy. Of these, 6 cases of endometrial cancer were detected, equating to 5.6% of all referrals.
Conclusions: The incidence of endometrial carcinoma in patients presenting with postmenopausal bleeding is 5.6%. Less than half of all referrals during this time met the criteria for hysteroscopy and biopsy. NICE guidelines (2012) infer that the pick up rate is expected to be 10%. These findings suggest that the two week wait results in over referral for invasive and costly investigations for women who do not have a diagnosis of endometrial carcinoma.

P39- Factors Affecting Surgeons' Decisions about the type of Hysterectomy they perform: A Qualitative Study

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Summary- Majority of hysterectomies in the UK are performed through an abdominal approach. This is despite robust evidence in favour of vaginal and laparoscopic approach.This study aimed to find out what

factors influence decision regarding the mode of hysterectomy offered. Although this question has been addressed in various studies in the past, no UK study has explored this.

Aim -The main aim of this study was to explore the gynaecologists' views and factors that influence surgical decision making on the type of hysterectom offered.

Methodology-This is a qualitative study for which NHS consultants practising benign gynaecology in the northwest of England were interviewed. A total of 22 participants were interviewed.

Results-Key factors influencing surgical decision-making were surgeons' perceptions of an increase in clinical indications of hysterectomy for which an abdominal route was more appropriate. Abdominal route was also often preferred due to familiarity. They felt that there was a lack of training in vaginal and laparoscopic hysterectomy. Due to this, many surgeons expressed concerns about higher complications with minimal access routes in their hands. Low case load, time pressures and lack of organisational support were other influencing factors which favoured abdominal route.

Conclusions Most surgeons prefer abdominal hysterectomy as this is the route they feel most comfortable with. Lack of training and experience are the main contributing factors limiting the use of minimal access approach. Most surgeons want to develop their laparoscopic skills but similar desire is lacking towards vaginal hysterectomy.

P40- Findings of a quality improvement survey

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In order to improve the quality of care we offer to our patients, we are undertaking a telephonic survey of patients who had treatment of endometriosis in our unit. It is an on-going survey and the results are interesting.

The information below is based on the data available as of now. On an average the patients suffered for 5 years with pelvic pain before seeing the GP. 6 patients saw the GP more than 10 times before being referred to a specialist clinic. The gap between GP referral and appointment with the endometriosis team ranged from 2weeks-4months. The satisfaction scores with initial consultation, explanation of the disease condition, ability to directly access an endometriosis specialist nurse were high being 9.3, 8.7 and 9.5 out of 10 respectively. The patients felt that their views were respected with the average score being 9.1. However, not all were happy with the explanation of surgery preoperatively with the average score being 8.3. The likelihood of recommending the unit to a friend or family was 9.8.

The key areas where the patients wished to see improvement were – GP education regarding endometriosis symptoms, waiting times for surgery, operation cancellation, inability to see consultant post op due to split site working, inability to see consultant on follow up and being discharged too soon after surgery.

Even when there were complications, patients commented on the care being excellent emphasizing the importance of candour, good communication and teamwork.

P41- Grading quality of preoperative endometrial biopsy in endometrial cancer

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INTRODUCTION

When women present with postmenopausal bleeding, following an ultrasound or hysteroscopic assessment, an endometrial biopsy may be performed. This biopsy informs the clinician regarding the histological subtype and the grade of differentiation of the cancer. Accurate preoperative grading is important in determining the place of care, counselling the patient about the extent of recommended surgery and forewarning the patient regarding potential adjuvant chemotherapy. This retrospective study examines the grading quality of preoperative biopsy.

METHOD

Patients who were diagnosed with endometrial cancer between 2008 and 2013 were identified through the histopathology database. The sensitivity, specificity, positive and negative predictive values and grading accuracy of preoperative biopsy was determined using final histology.

RESULTS

During the six year period, 158 women had surgical treatment for endometrial cancer. 46 patients were excluded because of lack of complete dataset or because of sarcomatous diagnosis. Complete set of data was available for 112 women. The sensitivity of preoperative grade 1, 2 and 3 are 61.5%, 61.5% and 81%, respectively. The specificity of grade 1, 2 and 3 diagnoses are 91.7%, 73.3% and 84%, respectively. PPV of G1, G2 and G3 are 80%, 41% and 71.4%, respectively. NPV of G1, G2 and G3 are 81.5%, 86.3% and 90%, respectively. The overall accuracy of G1, G2 and G3 are 80.4%, 70.5% and 83%.

CONCLUSION

Preoperative biopsy grading performance is moderate in quality. Randomised comparative trials of sampling techniques are required to define performance benchmarks. Accurate preoperative grading has potential implications for patient counselling, logistics, outcomes and resourcing.

P42- Gynaecological day case surgery: A snap shot view to improve cost-effectiveness

Lakshmi Sandu-Aana[1*], Rizwana Yakub[1], Uzma Ahmed[1], Sarah Carter[1], Gaity Ahmad[1]

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BACKGROUND: The current NICE recommendation is for 75% of elective surgery to eventually be performed as day-case. Effective day-case surgery minimises hospitalisation whilst optimising efficient patient care and cost-effectiveness.

AIMS: Our service set-up for gynaecological surgery comprises of two sites specifically for day-case and one for inpatient procedures. Day-case procedures are routinely being done in the operating list at the inpatient site and this significantly increases 'bed pressure'. The aim of doing this study is to assess the efficiency of operative care and timely discharge of the day case procedures being done at the inpatient site.

SUBJECTS AND METHODS: We prospectively reviewed 100 day case patients at the inpatient site. We obtained the following information (1) Type of the procedure (2) Intra-operative/Post-operative complications (3) Reason for delayed discharge

RESULTS: 20% of the patients were not discharged on the same day. 9 % of patients had medical reasons for delayed discharge. The common reasons for extended stay included delayed medical review, consultant choice and afternoon surgery. There were no intra-operative complications. 6% of patients developed postoperative complications such as pyrexia, high drain output and anaesthetic complications.

CONCLUSION: Our study has highlighted the lack of local protocol and areas for improvement to avoid unnecessary inpatient stay at hospital. We aim to develop robust local protocols which stipulate; a clear pathway and co-ordinated nurse-led discharge under clinical leadership to make this service cost-effective in the current NHS climate.

P43- Gynaecological review in the ED. A trainees perspective

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Introduction:
To evaluate the views of O&G trainees regarding gynaecological assessment in emergency departments in the Northwest England.
Methods:
An anonymous internet survey tool was used to gather data.
Results:
Of the 156 surveys, sixty two (62) responses were received. Fifty-six (55.7%) of those responded. Most trainees are working in units with greater than 4500 deliveries per annum. Fifteen percent (14.7%) and eighty six (86.3%) of the examinations are done by ED doctors and O&G doctors respectively. Ninety one percent (90.9%) have an agreed protocol for referral to emergency pregnancy assessment unit (EPAU). Fifty five (54.8%) stated that there is no direct access to emergency gynaecology outpatients at their hospitals and only forty eight percent (47.9%) have a referral protocol in A&E to the clinic. Forty four percent (43.9%) confirmed a lack of rooms with adequate patient privacy. Approximately a third (32.5%) reported that speculum examinations are not performed due to lack of privacy in A&E. Two thirds (66.7%) of the trainees state that they have encountered delayed referrals by A&E staff. Nearly half (46.3%) of the trainees state that patients aren't reviewed by medical staff in A&E before being transferred to a O&G ward setting.
Conclusion:
The majority of gynaecological examinations in emergency departments appear to be being performed by gynaecological staff. There appears to be strong evidence of suboptimal conditions for reviewing gynaecological patients. Clear protocols can improve patient satisfaction and reduce the burden on already overstretched departments

P44- Harmonic instrumentation significantly reduces the mental load compared with diathermy during simulated laparoscopic salpingectomy: A Randomised Cross-over Trial

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Introduction
Laparoscopic salpingectomy (LS) is an essential gynaecological procedure, which may be performed for tubal ectopic pregnancy or ovarian cancer risk reduction. Harmonic devices are purported to offer superior ergonomics. This study examines the impact of instrumentation on surgeons' mental load.
Method
Nine participants were stratified at recruitment to this cross-over randomisd comparative study, using computer generated allocation. Participants were first trained to proficiency in salpingectomy. All the performances were completed on LAP Mentor virtual reality simulator which captured the dexterity metrics and simultaneously recorded videos of the procedures. Each participant performed a salpingectomy using harmonic and diathermy (bipolar/monopolar) techniques during separate sessions. During the salpingectomy participants were required to perform simultaneously, a validated visuo-cognitive secondary task. After the procedures, participants completed two validated questionnaires - NASA-TLX and subjective mental effort questionnaire (SMEQ).
Results
In all six dimensions of NASA-TLX, harmonics resulted in significant improvement in workload measures [mental demand (P=0.02), physical demand (P=0.008), temporal demand (P=0.004), performance (P=0.007), effort (P=0.02) and frustration (P=0.003). SMEQ measure also reflected significant reduction in mental load associated with harmonic instrument (P=0.037).
The visuo-cognitive secondary task measures of mental load, revealed a significant reduction associated with harmonics: the overall detection rate (P=0.0004) and correct detection rates (P=0.0004) were significant.
Pearson correlation coefficient between mental load (NASA-TLX) and SMEQ was 0.74 for diathermy group and 0.76 for the harmonics group, thus demonstrating a moderately strong concurrent validity of outcome measures. This fortifies our findings.
Conclusion
Harmonic instrument significantly reduces mental load during simulated laparoscopic salpingectomy.

P45- Homemade Simulation Training - Does It Work?

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Aims/Objectives: To determine if a low cost task-based simulation training course, using household and DIY items, can improve laparoscopic surgical skills
Background: The surgical competencies required to perform laparoscopic surgery are challenging and require a period of intensive learning. The validity and benefits of simulation in gynaecological surgical training are being increasingly recognized. Indeed, the recent RCOG document 'Becoming Tomorrow's Specialist' recommends simulation training not only for trainees but also for continuous professional development throughout a career as a gynaecologist. Despite this, the availability of simulation training is patchy and costly.
Methods: Using household and DIY items twenty tasks were devised for individual use in a laparoscopic 'box trainer'. Sixteen gynaecology trainees spent six hours practicing these tasks. Each trainee was timed at completing four tasks before and after practice. Eight laparoscopically naive medical students were also timed at these four tasks.
Results: Compared to the medical students, the trainees did not perform the four test tasks significantly faster at baseline. However, after practice, the trainees showed a significant improvement in the median time taken to complete three of the four test tasks. On direct questioning all the trainees felt their laparoscopic skills had improved significantly as a result of practice.
Discussion: Time needed to complete a set task is a marker of hand-eye co-ordination and dexterity, an essential part of laparoscopic surgery. The overall improvement in the trainee's timings suggests practice improved these modalities.
Conclusions: A low cost, task-based simulation-training course can improve laparoscopic skills for gynaecology trainees.

P46- How do we best prepare our patients for their outpatient services appointment?

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Introduction: This study aims to assess the value of our patient information leaflet with regard to improving their out-patient hysteroscopy experience.
Material and Methods: We analyzed data from a questionnaire given to 74 women after outpatient hysteroscopy.

Results: 84% of women had received our information leaflet prior to their appointment. Of these women who received the leaflet in advance, 20% reported a pain score of 5 or less whereas only 8% of women who did not receive the leaflet reported pain scores of 5 or less.
Also, only 12% of those who had received our leaflet reported pain scores of 8 or more but 25% of the women who did not receive a leaflet reported such scores.
Only 14% of women took oral analgesia before the procedure.
85% of women were satisfied with the information leaflet they received before having hysteroscopy .
73% of women rated their experience as 10 (scale 0 - 10).100% were satisfied with the staff.
Women with no analgesia gave higher pain scores compared to those who took oral analgesic pre- procedure. There was no significant difference in pain scores between women taking only oral analgesics compared with those who had local analgesia.
Discussion: This study highlights the importance of a high quality patient information leaflet as reflected by the lower pain scores reported by the women who received information before the procedure compared to those who did not.

P47- How does histopathology correlate with the indication for hysterectomy?

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Hysterectomy is one of the most common gynaecological procedures and provides a definitive cure for many benign diseases, but is sometimes associated with significant morbidity. Alternatively there are effective conservative treatment options available for such conditions.
Objective:
To correlate the indication for hysterectomy with the histopathology.
Design:
In this retrospective study, 189 hysterectomies performed at a University teaching hospital during a one year period were analyzed. The indications for surgery and the histopathological findings were correlated.
Results:
The majority of the procedures were done laparoscopically (54.5%) and vaginal hysterectomy was done in 35.5% of the cases.
The commonest indication for hysterectomy was genital prolapse in 58 cases (31%) followed by menstrual disorders in 56 cases (30%) and chronic pelvic pain/endometriosis in 51 cases (27%).
Sixty one percent of specimens from cases of chronic pelvic pain/endometriosis showed abnormal histology. Analyzing menstrual disorders further, when the indication for hysterectomy was DUB (without endometrial ablation), abnormal histology was found in 30% cases only. Whereas if it was done for post ablation pain or bleeding, abnormal histology was found in 73% of the cases.
Discussion:
Histopathology from cases of chronic pelvic pain/endometriosis and post ablative problems showed abnormal pathology in majority of the cases vindicating the need for surgery. However, when the indication was DUB (without offering ablation), only one third cases showed abnormal pathology. Hence it is prudent for each unit to conduct regular audit of hysterectomies correlating indication and diagnosis, in order to justify the need for major operative intervention.

P48- Hysteroscopic sterilisation : An advancing alternative to laparoscopic surgery?

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Hysteroscopic sterilisation by tubal cannulation and placement of intrafallopian implants has been approved by NICE since 2009 and current literature suggests it is an effective, safe and well tolerated alternative to laparoscopic sterilisation.
The Essure insert system was introduced early, locally within the North West and as there are no clear national auditable standards we performed a retrospective case series of patients who have had hysteroscopic sterilisation performed from 2011 to 2015 (n= 60).
Through excel, data has been analysed to confirm adherence to NICE and FSRH guidance looking at consent, patient information, safety and procedure performance. Particular interest locally is to improve patient compliance with follow up in confirming bilateral tubal occlusion and to look at complications to maintain high procedural success rates and patient satisfaction, comparable to national data. Local guidance will be produced from this data to provide auditable standards.
At present we are yet to fully analyse the data however provisional results show hysteroscopic sterilisation is a safe, cost effective and well tolerated procedure with high rates of patient satisfaction. To date, both short and longer term complications are low and suggest to be less prevalent than with laparoscopic procedures.

P49- Indication and Outcome of Repeat Hysteroscopy Under General Anaesthesia Following Outpatient Hysteroscopy

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Aim: To determine the indication and outcome of patients referred for hysteroscopy under general anaesthesia following outpatient hysteroscopy at Croydon University Hospital.
Method: Retrospective audit of hysteroscopies performed under general anaesthesia following outpatient hysteroscopy over a 3 month period at Croydon University Hospital. Indication for referral, correlation of operative findings, and outcome were reviewed
Results: 89 hysteroscopies performed under general anaesthesia, 30 (22 for PMB, abnormal PVB >45yo, 1 HMB <45yo, 5 incidental findings of thickened endometrium) of these were referred following an outpatient hysteroscopy appointment. 14 were referred due to unsuccessful hysteroscopy - 12 unable to enter (2 of these remained unsuccessful under GA), 2 withdrew consent. 9 were referred due to diagnosis of polyps during the outpatient procedure - 2 of these had an attempt at polypectomy (1 unable to tolerate, 1 unsuccessful 21mm), 7 had no attempt at polypectomy (1 had no polyp on repeat hysteroscopy, 3 had polyps <15mm, 3 had polyps 20-40mm). 6 were referred due to insufficient sample (4 of these had normal hysteroscopic findings). 1 was referred due to persistent PMB (atrophic endometrium and insufficient sample during outpatient procedure). 14/16 successful diagnostic outpatient hysteroscopies correlated with the intraoperative findings under GA. No malignancies were diagnosed in this small group of repeat hysteroscopies.
Conclusion: Insufficient histological sample with normal outpatient hysteroscopy should not be an indication for repeat hysteroscopy under GA. Review of local skill and training in outpatient hysteroscopy and resection.

P50- Intergration of fast track and outpatient hysteroscopy services. Questions and answers to help to create a successful outpatient hysteroscopy service

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Introduction:The leading role of hysteroscopy in the investigation of endometrial pathology is well known. With the development of new

technology and the expanding role of outpatient hysteroscopy it is very important to understand the benefits and safety of outpatient hysteroscopy. We combined outpatient hysteroscopy service and Fast Track service to investigate postmenopausal bleeding and created a pathway to streamline the patient's journey. **Material and Methods**: We performed a 6 month retrospective study of 165 post menopausal women, referred from Fast Track to outpatient Hysteroscopy Clinic and seen within two weeks of referral. The indications were post menopausal bleeding and increased focal endometrial thickness (> 5 mm), suspicion of polyp on ultrasound, inability to obtain sample in Fast Track clinic and non-diagnostic sample. Rigid or flexi hysteroscopes were used. All women had endometrial biopsy. **Results**:Most of patients were able to be seen and complete investigation and treatment in One Stop Outpatient Hysteroscopy clinic. 10% declined outpatient hysteroscopy or had referral cancelled due to finding of endometrial carcinoma on Fast Track biopsy. Hysteroscopy in postmenopausal group revealed 29% normal endometrium, 44.24% endometrial polyps, 7.27% fibroids, 0.6% with endometrial cancer. No perforations were seen. 15% of patients needed cervical dilatation. **Discussion**:It is very important to take these results, showing a high rate of abnormal findings, into consideration and to create a pathway that can achieve better integration of these two services to investigate symptoms in women with high risk of cancer.

P51- Is Endometriosis a risk factor for ectopic pregnancy?

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IntroductionThere are multiple risk factors for ectopic pregnancy. Tubal pathology, caused by previous surgery, pelvic infections or endometriosis[1,2] is known to be a strong risk factor. Endometriosis alone may double the risk[3], however some authors have disputed this[4-7]. We sought to investigate if endometriosis truly is a risk factor for ectopic pregnancy.
Methods Retrospective review of 698 patients with an ectopic pregnancy who underwent laparoscopic surgery between 2004-2014 at a multiethnic district general hospital in London. The presence or absence of endometriosis was identified and known risk factors compared between the 2 groups.
Results 36 (5.2%) had endometriosis and 662 (94.8%) had no evidence of endometriosis. 34 (94%) had grade 1-2 disease, 2 (6%) stage 3 disease and 0 stage 4 disease. Mean age was 31 in both groups. No significant difference between tubal or extra-tubal ectopic location (p0.33) was identified. Significantly, 75% with endometriosis were nulliparous and 0% had a previous ectopic pregnancy, whilst it was 46% and 11% respectively in those without endometriosis (p0.0008 and p0.03). 11% with endometriosis conceived using Artificial Reproduction Techniques (ART) and 4% without endometriosis (p0.04).
Discussion We believe that endometriosis per se is not a risk factor for ectopic pregnancy, at any site, as the prevalence in those with ectopic pregnancy over the last 10 years is equivalent to that of the general population; 2-10%[8,9]. However, those with endometriosis had a statistically higher chance of being nulliparous and needing ART, which does independently increase the odds of ectopic pregnancy.

P52- Is robotic sacrocolpopexy really necessary?

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Objective: The use of robotic surgery is increasing rapidly. Proponents for robotic sacrocolpopexy(RS) advocate similar operating times, outcomes and a faster learning curve compared to laparoscopic sacrocolpopexy(LS). This is at the expense of high setup and procedural costs.
The aim of our study was to compare our unit's LS operating times to the published RS operating time data and the impact that this would have on a busy unit if RS were to become the 'standard'.
Method: We used an electronic theatre management system to identify LS performed between July 2011-March 2015 by a single,subspecialist urogynaecologist in a busy DGH. Demographic data included age,BMI,and parity. Perioperative data included,operating time,estimated blood loss,complications and length of stay.Six week follow-up looking at prolapse grade was used to calculate success rate.
Results: Seventy-three patients were identified, 21 were excluded due to concomitant procedures. Of the 53 patients that were included, the average age was 57.9 years, parity 2.3 and BMI 19-36. The mean operating time was 89.5 minutes compared to 230.5 minutes for RS. The average blood loss was less than 100 millilitres. There were no documented complications and the length of stay was 1 night. Both subjective and objective outcomes were good.
Conclusions: Most reports claim an equivalence between standard laparoscopic surgery and robotics in all but cost. In a unit with a high volume of LS, operating times are significantly shorter by a factor of almost 3. Combined with increased costs this would make RS entirely unfeasable in standard practice.

P53- Laparoscopic ability is an invaluable skill in unexpected cases

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A 39 year old was referred to Gynaecology clinic with recurrent dyspareunia and vaginal discharge 1 year after abdominal hysterectomy for menorrhagia.
Speculum examination showed granulation tissue in the vault and the plan was for removal of granulation tissue under anaesthesia.
On attempting to remove the tissue, further tissue prolapsed and it was thought to be fallopian tube in origin. This diagnosis was queried initially and the patient had been consented for laparoscopy. Having not seen a case like this before it was decided a laparoscopic approach would give us the conclusive diagnosis and on investigation it was a fallopian tube prolapse (FTP). Having the ability to perform laparoscopically allowed for quick definitive diagnosis and the patient had a laparoscopic bilateral salpingectomy and subsequent repair of vault defect vaginally under laparoscopic vision.
Systematic review by Ouldamer et al. found 51 cases of FTP following hysterectomy. This review looked at multiple management options, which ranged from silver nitrate application, resection of prolapsed tissue and then laparoscopic management. This review determined that laparoscopy was the most effective management with these cases with reduced recurrence and better symptom relief.
Having laparoscopic abilities at your disposal is invaluable in unexpected situations such as these and can greatly benefit patient management. The presentation of vault granuloma following hysterectomy needs to be reviewed as a potential FTP until proven otherwise. This is a rare complication following hysterectomy that can lead to potentially serious complications (peritonitis) and is a risk for clinicians to be aware of.

P54- Laparoscopic Bowel Injuries: The importance of early recognition and treatment

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Introduction
Complex gynaecological procedures are increasingly performed laparoscopically exploiting the benefits of shorter hospital stay and rapid recovery. Complications may be more subtle and not recognised

immediately with delayed treatment contributing to serious morbidity and mortality. The incidence of intestinal injuries is 0.06%-0.5% for diagnostic laparoscopy rising to 0.3%-0.5% for operative laparoscopy[1], relating mainly to entry complications, electro-surgery and port-site herniation.

Case Series

Patient outcomes following eight cases of bowel injury relating to laparoscopic adhesiolysis, excision of endometriosis, oophorectomy and hysterectomy are discussed. 37.5% of injuries were detected intra-operatively and better outcomes followed with no need for bowel resection, blood transfusion, additional surgery or readmission, with an average length-of-stay in this group of 2 days (range 1-3). Bowel injuries not recognised immediately had their diagnosis delayed by an average of 4.8 days (range 1-12) and 100% required stoma formation with an average of 1.8 additional surgeries (range 1-3) and 3.4 hospital readmissions (range 1-7). These patients stayed an additional 34.5 days in hospital (range 11-90). Intervention was delayed further if the patient was discharged before the injury was diagnosed (6.3 days) compared to those diagnosed postoperatively during the primary admission (2.5 days). Early warning scores and biochemical markers were not discriminatory, but symptoms of abdominal pain, anorexia and reluctance to mobilise were common features.

Summary

These cases highlight the significance of failing to promptly recognise bowel injury or post-operative deterioration. Gynaecologists should be vigilant through thorough patient selection, careful operative technique, assessments of bowel integrity and post-operative management.

P55- Laparoscopic Entry Technique – review

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Techniques used in laparoscopic entry depend on experience and preference of surgeon and complexity of operations undertaken.

At least 50% of laparoscopic complications occur prior to commencement of intended procedures.

Studies suggest that 30-50% of bowel injuries and 13-50% of vascular injuries are undiagnosed at the time of surgery.

To minimize entry-related injuries several techniques, instruments, and approaches have been introduced.

Closed entry – Veress needle

Most popular between gynaecologist.

Pre-peritoneal insufflation: 2.7%, 15%, 44.4% and 100% of cases at one, two, three, and more than three attempts respectively.

Umbilical infection: 1%.

Bowel injury: 0.04% - 0.2%

Vascular injury: 0.03% - 0.2%

Carbon dioxide embolism: 0.001%

Open entry – Hasson technique

Prevention of gas embolism and pre-peritoneal insufflation.

Longest laparoscopic entry, gas leak.

Umbilical infection: 0.4%.

Bowel injury rate: 0.05% - 0.5%,

Vascular injury: 0% - 0.005%

Direct trocar entry

Avoidance of failed pneumoperitoneum, pre-peritoneal insufflation, carbon dioxide embolism.

Fastest abdominal entry.

More than three attempts to enter the abdomen in 2.7%.

Failed technique: 0.4% - 1.4%

Bowel injury: 0.05% - 0.1%

Vascular injuries: 0%

Perforation of omentum: 4.8%

Optical trocars (Visula entry system)

Permits visually guided trocar entry without insufflation and easy recognition of injuries at the time of entry.

Quicker than Veress and Hassan

Bowel injury: 0% - 2%

Mesenteric injury: 0.1%

Vascular injury: 0.04%

Complication rate related to laparoscopic entry remained the same during the last 25 years. There is no clear evidence as to the optimal form of laparoscopic entry in the low-risk patients.

P56- Laparoscopic entry techniques - 2014 Cochrane Review update

David Gent[1*], Daniel Henderson[1], Kevin Phillips[2], Andrew Watson[3], Gaity Ahmad[1]
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Background

Complications from laparoscopy are often related to the initial entry into the abdomen and range from life-threatening (e.g. visceral injury) to minor (e.g. extraperitoneal insufflation). There is no clear consensus as to the optimal method of entry. We present the second update to the 2008 Cochrane review on laparoscopic entry techniques**.**

Methods

The review used the search strategy developed by the Cochrane Menstrual Disorders and Subfertility Group. MEDLINE, EMBASE, CENTRAL and PsycINFO were searched up-to August 2014.

Results

46 randomised controlled trials with 7,844 individuals that underwent 13 different laparoscopic entry techniques were included. No advantage was identified of using any technique to prevent major vascular or visceral complications. Significant reduction in the incidence of failed entry, extraperitoneal insufflation, and omental injury for open-entry compared to a Veress Needle technique; and in vascular injury in the direct-trocar group compared to the Veress needle entry group were identified.

A reduction in trocar site bleeding was associated with radially expanding access system (STEP) trocar entry compared to standard trocar entry; and an advantage of not lifting the abdominal wall before Veress Needle insertion for failed entry.

Conclusions

There is a significant reduction in failed entry, but no difference in the incidence of visceral or vascular injury for open versus closed-entry techniques. Low rate of complications are associated with laparoscopic entry however small participants numbers within these studies may account for lack of significant difference in associated major complications between entry techniques.

P57- Laparoscopic Hysterectomy for Endometrial Cancer - Surgical Outcomes in a District General Hospital Cancer Unit

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Background: Endometrial cancer is the most common gynaecological malignancy in the UK. Most women present with early stage disease when surgery alone may be adequate to achieve cure. NICE Guidance [IPG356] states that the current evidence on the safety and efficacy of laparoscopic hysterectomy for endometrial cancer is adequate to support its use. Laparoscopic hysterectomy is the offered route of choice offered in our Gynaecology Cancer Unit.

Aim: To investigate peri-operative outcomes for women undergoing surgery for endometrial cancer.

Methods: Retrospective case review audit comprising 2 years of patients undergoing hysterectomy for endometrial cancer within our unit.

Results: We identified 34 cases. Of these 31 (91%) had a laparoscopic procedure. Two open procedures were carried out due to pre-existing co-morbidities, and there was one conversion due to the presence of dense adhesions. There were no intra-operative complications. 32 had an estimated blood loss of less than 500ml (94%) and none required transfusion. There were no major post-operative complications. Six women experienced minor complications (18%) with just one requiring readmission. Our average hospital stay for laparoscopic hysterectomy was 1.5 days.
Conclusions: This audit has confirmed that we safely offer a laparoscopic approach to women requiring hysterectomy for early endometrial cancer within our Unit. Our rates of complications are comparable to reported rates in the literature despite our unit achieving one of the highest laparoscopic surgery rates in our region.

P58- Laparoscopic Hysterectomy for endometrial cancer: Analysis of eighty-seven cases from a cancer unit, Greater London

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Background.
Endometrial cancer is the most common gynaecology cancer in the UK and often presents with postmenopausal bleeding. Stage 1 disease is treated surgically by total hysterectomy with bilateral salpingo-oophorectomy (BSO). Previously an open approach was mainstay, however use of total laparoscopic hysterectomy (TLH) with BSO is now supported as a surgical modality for endometrial cancer.
Materials and Methods.
Women proposed for surgery following multidisciplinary review for suspected gynaecology malignancy were included. All cases for TLH and BSO were included between 21/11/2011 and 27/02/2015. Information regarding patient age, surgery, length of stay, histology and complications was recorded onto an excel database. Information was analysed and compared to current NICE guidance.
Results.
Eighty-seven cases were included, the median age of the patient was 58yrs. Five cases underwent TLH only and the remaining underwent TLH and BSO. Results of histology demonstrated 39.4% were benign, 4.6% simple hyperplasia, 10.8% complex hyperplasia, 8.04% complex hyperplasia with atypia, 34.5% endometrial carcinoma, 2.3% metastatic endometrial carcinoma, 4.6% CIN, 1.15% GCIN, 1.15% borderline ovarian tumour 1C and 2.3% Lynch syndrome. The complication rate was 10.3%. The conversion rate to TAH was 3.45% (n=3). One case resulted in a laparotomy due to bowel perforation, there was one wound infection and four bladder injuries (4.59%). The median length of stay was 2 nights.
Conclusions.
Analysis of the cases performed in our unit is comparable to those reported in the literature supporting this method. As illustrated in this study it offers a number of advantages compared with open approaches.

P59- Laparoscopic hysterectomy training for endometrial cancer surgery: Validation of a virtual reality simulator

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Introduction
Laparoscopy is the preferred route for hysterectomy. Surgical errors are more prevalent during the learning curve. High quality evidence supports simulation based training over standard training. Prior to adopting a simulator, the device must be tested for face and content validity. We present the first study of a hysterectomy simulator.

Methods
Twelve consultant and five subspecialty trainees who are certified to perform TLH for endometrial cancer, were recruited. The Simbionix virtual reality simulator offers a hysterectomy module and suturing tasks. The participants performed TLH + BSO and vault closure before completing the assessment. Participants rated the ten features of face validity and the seven features of content validity using a ten point Likert scale: a score of one equals minimum and ten indicates maximum. Qualitative feedback was captured.
Results
The face validity assessment scores were high, with median scores ranging 7-9: instruments' appearance (9), instrument manoeuvring (8), instrument functionality (8), tissue appearance (8), response to manipulation (7), depth perception (7), hand-eye coordination training (8), bimanual coordination training (8), value as a training device (8) ergonomics (7). The scores for content validation are uterine manipulation (9), IP ligament (8), bladder dissection (7), UA (8), colpotomy (7), identification of ureter (7) and vault closure (4).
Discussion
The study demonstrates face and content validity of the VR-LH simulator. The vault closure task on this VR simulator was not highly rated. We believe this simulator will enhance the learning of LH. The next steps would be assessments of construct validity and learning curves.

P60- Laparoscopic hysterectomy: Experience of a British district general hospital

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Introduction Hysterectomy is the most frequently performed major gynaecological operation. In the UK the rate of hysterectomy is 42/100,000 population, with higher-rates in the United States (143/100,000) and 236/100,000 in Germany. It is interesting to note that while the trends showed a decline from the 1990's to early 2000, from 2002 till date the rates show a plateau.
Method This is a retrospective study of hysterectomies performed in North Devon District Hospital (NDDH) in UK over a period of one year (2014). Types of hysterectomies were analysed in light of the NICE guidelines standards November 2010 – interventional procedure guidance 356 and the Hospital Episode Statistics (HES).
Results 165 hysterectomies were performed during the period of the study. The rate of vaginal, abdominal and laparoscopic hysterectomy at the NDDH was 58.7%, 7.8%, 28.5%, compared to 35%, 66% and 3% of the national rate respectively.
The mean length of hospital stay after laparoscopic hysterectomy was 2 days compared to 4.6 days for abdominal hysterectomy. The mean operative time was 120 minutes compared to the national reported time in NICE guidelines of 111 – 168 min.
The rate of conversion was 5.4% compared to the reported 7% in the NIIC guidelines. The rate of intra-operative and post-operative complications was 2.8% and 5.6% compared to national rates of 10% and 17% respectively with a re-admission rate of 1.8%.
Conclusion This retrospective study reflects the current practice regarding one of the commonest gynaecological operations in one of the district hospital in the UK.

P61- Laparoscopic Location of sentinel lymph node in cervical carcinoma and factors affecting bilateral detection

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Retrospectively analysed data for the laparoscopic detection of the sentinel lymph nodes (SLN's) in early cervical cancer patients: FIGO Stage 1a1 (with LVSI) - 1b1. We looked at the anatomical location of the SLN and factors associated with unilateral detection, utilising intraoperative gamma probe and blue dye. All patients were consecutively treated between January 2005 and January 2015 at the Wet Kent Gynaecological Oncology Centre, Maidstone Hospital, Maidstone, UK.
The aim of the study was to document locality of SLNs in cervical carcinoma and examine factors affecting unilateral detection during laparoscopic surgical procedures.
A total of 84 women were investigate with a combined intra-operative approach. The 70% (N=59) of the patients presented in FIGO Ib1, 17% (N= 14) in Ia2 and 13%(N=11) in Ia1 stadium. In total 24 patients (28.6%) had lymph vascular space invasion (LVSI).
The most common SLN location was the external iliac region in 38.5% of the patients, 23.8% was in the internal iliac, with a percentage being identified in less common sites (obturator area, common iliac, para-aortic and pre-sacral areas).
SLN were detected unilaterally in 15 patients (17.9%), bilaterally in 66 patients (78.6%) and no sentinel node was found in 3 patients (3.5%).
Of all factors analysed only older age and higher BMI were associated with unilateral detection of the SLN.

P62- Laparoscopic management of a rudimentary horn pregnancy using EnSeal

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Background
Rudimentary horn pregnancy is a rare form of ectopic pregnancy with an incidence ranging from 1:76,000 to 1:140,000[1]. It carries a high risk of rupture, in the late first or mid-second trimester, with potentially life threatening intra-abdominal haemorrhage. Laparoscopic management is reported in only 9 cases. This is the first case of laparoscopic management using EnSeal.
Case
A 31 year old, G3P1, presented at 11 weeks gestation with lower abdominal pain. Ultrasound suggested an ectopic pregnancy within a non- communicating horn of the uterus. It was confirmed by MRI. The rudimentary horn and products of conception were removed laparoscopically using EnSeal. The patient recovered well and was discharged next day.
The rudimentary horn was dissected and ligated with EnSeal, it was cut into slices with EnSeal, allowing removal through the laparoscopic port.
Discussion
We present successful management of an 11 week gestation rudimentary horn pregnancy. EnSeal enabled bloodless dissection of the vascular pedicle and small sample size enabling easy laparoscopic retrieval. It further widens the scope of EnSeal in laparoscopic surgery.
Reference
1. [1] Nahum GG (2002) Rudimentary uterine horn pregnancy: the 20th-century worldwide experience of 588 cases. J Reprod Med 47:151-163

P63- Laparoscopic management of giant ovarian masses: case report of a 44-litre cyst

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The RCOG/BSGE guidance and Cochrane review state that laparoscopic management of ovarian cysts is preferable due to reduction in adverse intra-operative events, pain and length of hospital stay. However, there is insufficient evidence to guide our management of large or 'giant' ovarian cysts.

We aim to demonstrate that laparoscopic management of giant ovarian cysts is possible and may indeed be preferable in carefully pre-selected patients.
We report the case of a 44 year old lady whose CT scan revealed a massive pelvic mass 43x40cm, most likely ovarian in origin. Insufflation of the abdomen was not possible prior to deflation of the cyst and so 44 litres of serous fluid were drained through the umbilical port, after the trocar was inserted directly into the cyst. Once the sac was deflated it was removed through the lateral port after being bought to the surface in an endobag. The cyst wall was then extracted with Kocher's forceps. Histology confirmed a large benign paraovarian serous cyst.
Spillage of potentially malignant cyst contents should be avoided but according to the RCOG/BSGE, in pre-menopausal women, the incidence of ovarian cysts being malignant is only 1 in 1000. Therefore, after individual risk stratification and frank discussion with the patient laparoscopic cystectomy may be the most appropriate management. Management of giant ovarian cysts laparoscopically remains a controversial issue, however we demonstrate that with careful patient selection, avoidance of the pit-falls of open surgery is possible, even in the largest of cysts.

P64- Laparoscopic management of post myomectomy sequelae

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A 37 year old Gravida 2 Para 0 lady was seen 10 months following a difficult myomectomy which was converted to a laparotomy from planned laproscopy. Presenting symptoms were ongoing discomfort and pain in the suprapubic region with an ultrasound showing a calcified 4 cm fibroid.
An MRI scan excluded a myoma but raised the possibility of a resolving collection in the myoma bed. With the histology of the fibroid while benign had features of a mitotically active myoma, a recurrence with degeneration was also suspected.
Follow up ultrasound scans failed to show resolution and a repeat laparoscopy was undertaken.
At laparoscopy a firm mass of 3 cm in the right lateral aspect of the lower uterus underneath the bladder reflection was noted which corresponded to the area of tenderness and imaging. Once the bladder was reflected below this are a 1.5 cm defect was apparent in the anterior myometrial wall with a well defined cavity containing a dark brown fibrous degenerated material. The cavity was evacuated and a thorough lavage carried out followed by a two layered closure with intracorporeal sutures.
Histological examination confirmed the material to be consistent with documented appearance for oxidized cellulose. On reviewing the original operative notes it was apparent for haemostasis , multiple sheets of surgical were used to pack the myoma bed and extra peritonised thus delaying reabsorption.
Post operative ultrasound 8 weeks late showed normal uterine contour with complete resolution of symptoms.

P65- Laparoscopic management of ruptured ectopic pregnancy with major intra-abdominal haemorrhage (Over 1.5 L): Case series and demonstration of operative technique

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Ruptured ectopic pregnancy with significant intra-abdominal haemorrhage is an indication for emergency surgical management. The choice between laparotomy and laparoscopy have been always subject to debate, with more growing reports supporting the feasibility and safety of laparoscopic treatment in such cases.
Traditionally, laparotomy was the preferred choice for those cases, especially with haemodynamically unstable patients, due to perception that

laparotomy is quicker and easier to achieve haemostasis in such cases. Factors affecting choice included: surgeon's, anaesthetist and theatre team laparoscopic experience, availability of laparoscopic instruments, patient observations and estimated intra-abdominal loss.
Our work represents case series of three cases of acutely ruptured ectopic pregnancies, with massive intra-abdominal haemorrhage (Range= 1500 - 3500 ml). All the 3 cases were managed laparoscopically, with haemostasis achieved within 5 minutes of the start of the procedure.
The technique demonstrated could not have been achieved with a knowledgeable supportive theatre team, involving anaesthetists, nursing staff and surgeons. The readily available laparoscopic instrumentation facilitated quick procedure and prompt haemostasis.
The technique included: Rapid perioperative resuscitation, +/- bedside US scan. No uterine instrumentation, 10 mm Zero degree scope, 10 mm supra-pubic and 5 mm lateral ports. Quick and efficient suction of blood using a powerful 10 mm suction system. Haemostasis quickly achieved using Endoloop or Ligasure. Non-use of irrigation. Alternating patient position between trendleberg and ante-trendleberg.
In conclusion: Laparoscopic surgery is safe and effective for managing ruptured ectopic pregnancy with significant bleeding. The volume of intra-abdominal bleed should not be a limiting factor in experienced hands.

P66- Laparoscopic Myomectomy - A ten year learning curve

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Aim: Laparoscopic myomectomy (LM) is an organ preserving technique not only lending itself to enhanced recovery pathways, it has been described as the gold standard for certain fibroids and cases.
To review LM over a ten year learning curve, including peri-operative outcomes and resolution of symptoms/patients satisfaction.
Methods: Retrospective cohort study of 217 consecutive single surgeon LM performed at a London teaching hospital over a ten year period. A comparison was made between those cases performed in the first half of the data collection (first 5 years) with those performed in the second half.
Results: The demographics of the two cohorts of patients did not differ significantly. On clinical examination the size of fibroids selected were significantly larger in the second half of the study(13.26 vs 14.73, p=0.0089). There was no significant difference in the duration of surgery, number of fibroids removed and estimated blood loss over the ten years. There was an increase in the number of drains left in situ(0.44 vs 0.70, p<0.0001) and a significant decline in the number of complications (0.09 vs 0.02 p= 0.0156). In patient stay was reduced over time (2.40 vs 1.67, p<0.0001) whilst the resolution of patients symptoms improved (0.99 vs0.99, p=0.0014).
Conclusions: Our data shows that surgical performance of laparoscopic myomectomy improves over time and this is evidenced by a decline in complications and length of hospital stay. It also shows as surgical experience is gained the complexity of case selection increases, as does patient experience of symptoms resolution.

P67- Laparoscopic myomectomy - *an appropriate option for peri-menopausal women*?

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Aims: The decision to undertake a surgical approach in the management of uterine fibroids in peri-menopausal women can be controversial.
To compare peri-operative outcomes and symptom resolution of laparoscopic myomectomy(LM) in peri-menopausal and non menopausal women.
Methods: Retrospective cohort study of 217 LM performed between 2005 and 2013 for the management of uterine fibroids.
Results: The estimated blood loss(233.3 vs 305.1, p=0.2382) and drop in haemoglobin(1.13 vs 1.76, p=0.4512) was lower in the peri-menopausal group compared to non menopausal women, although this did not reach clinical significance. There was no difference in the use of surgical drains or length of hospital stay in both groups. The resolution of symptoms was comparable between patient cohorts, however the post operative patient satisfaction was greater in the non menopausal compared with the peri-menopausal women(0.91 vs 0.50, p=0.0128).
Conclusions: These findings suggest the surgical technique of LM is similar in both cohorts of women and not complicated by age. There was a slight reduction in estimated blood loss and drop in haemoglobin in the peri-menopausal group which could reflect the reduction in vascularity of fibroids at this age. Interestingly, whilst there was no difference in the resolution of symptoms between the groups, patient satisfaction was significantly less in the peri-menopausal women leading us to question whether surgical management is the most appropriate choice of management for them. This warrants further investigation into surgical recovery in peri-menopausal women and patient satisfaction with alternative forms of fibroid management to optimise treatment in this group of women.

P68- Laparoscopic port site Incision Hernia: A case report and review of literature

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Introduction:
Port site hernia following laparoscopic surgery is less common compared to incisional hernia following open surgery. It is important to increase awareness among laparoscopic surgeons of the possibility of intrafascial incisional hernia as clinical findings may be subtle and early CT diagnosis is necessary for timely surgical intervention.
Case Report:
We report a case of port site hernia in a 67 yr. old woman who underwent laparoscopic bilateral salpingo-oophorectomy for a 16 cm right ovarian cyst with low risk of malignancy. Our practice is to close the fascial layer for any port sites more than or equal to 10 mm laparoscopically under direct view. She was readmitted with nausea, vomiting on post operative day 4. Conservative management was unsuccessful hence an urgent CT scan was performed, which showed small bowel obstruction due to herniation at the left port site (extended for specimen retrieval). She underwent laparoscopic release of port site hernia and the peritoneal defect was closed with GraNee's needle under direct vision.
Discussion:
Trocar/ port diameter and access technique can affect the rate of hernia formation. Port site hernias appear to be related to large diameter ports used for specimen extraction, older age group , high BMI, increased operative times and excess tissue manipulation leading to fascial weakening. However, in spite of primary fascial closure of ports, hernia is still reported.
We recommend meticulous closure of fascia and peritoneum for port sites above 7 mm, with GraNee's needle or laparoscopic suture passer closure system under direct vision.

P69- Laparoscopic subtotal hysterectomy with power morcellation. A single centre experience

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Introduction:
Recent reports about the safety of power morcellation during laparoscopic subtotal hysterectomy (LSTH) have raised concerns because of the risk of intra-abdominal spread of unsuspected uterine malignancy. The AAGL and BSGE have released good practice guidelines for clinicians undertaking these procedures.
The aim of our study was to evaluate our practice of risk assessment, preoperative investigations and unexpected histology results in women undergoing LSTH.
Methods:
This was a retrospective single centre study from a tertiary university hospital. Consecutive patients that underwent planned LSTH from January 2010 until February 2015 were included. Medical records were reviewed for patient characteristics and outcomes.
Results:
One hundred and seven patients were identified. The median age was 46 years (range, 31-59). Preoperative endometrial sampling was obtained in 75 patients (70%). Nineteen patients (18%) had their last cervical smear more than 30 months before surgery. In the only postmenopausal patient of our cohort, the uterus was removed with an extension of the suprapubic skin incision without morcellation. Final histology demonstrated Smooth muscle Tumour of Unknown Malignant Potential (STUMP) in 2 cases and simple endometrial hyperplasia in 1 patient. All 3 patients have had no problems at follow up.
Conclusion:
Even though our cohort was small, there were however 2 unexpected histology results; although none of these patients had any adverse outcomes. Women undergoing LSTH with power morcellation should be appropriately selected and have adequate counselling about the procedure. Our preoperative work up can be improved and should adhere to guidelines in order to maintain safety.

P70- Laparoscopic Supracervical Hysterectomy (LASH): Are we looking for trouble?

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Objective:
To assess the safety, reproducibility and cost efficacy of LASH.
Methods:
Data was collected retrospectively, 143 women had LASH between August 2008 - November 2014 for benign indications with normal cervical smears and endometrial samples.
Initially one consultant performed the procedure and trained others. 4 consultants are now independently performing LASH.
2 patients towards the end of the study had morecellation in bag to comply with the recent FDA safety advice.
Results:
78% of LASH were performed for AUB, 88.3% had failed treatment. 17% were performed for chronic pelvic pain. The mean operating time was 90 min and mean blood loss was 136 ml.
3.4% had wound infection after LASH however only one pelvic haematoma, one ureteric oedema, one uterovaginal fistula, one hernia from lateral port site and one had scar pain at morcellator porte. No conversion to laparotomy, no blood transfusion, no DVT and no return to theatre.
Average theatre time was 70 minutes for open subtotal hystrectomy and 90 min for LASH. The average running theatre per minute is £3.08, giving £60 more for the LASH.
Instruments for LASH costs £1156 versus £200 for open. The average hospital stay for LASH was 1.7 nights versus 3.7 nights for open. Average cost for one night stay in hospital is £486. Overall cost of LASH was £2259.2 versus £2213.8 for open which obviously comparable with quick recovery and better patient satisfaction for LASH.
Conclusion:
LASH is safe, reproducible, cost effective and quicker recovery and less complication rates.

P71- Laparoscopic surgical approach in premenopausal ovarian cysts

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Introduction
As per RCOG guideline, 1 in 10 women have some surgery for ovarian cyst in premenopausal age group.
If surgery is needed, laparoscopic approach is the preferred way
We are reporting an outcome of how benign ovarian cysts were surgically managed in a tertiary care unit.
Methods
30 cases of premenopausal benign ovarian cysts were followed from first clinic appointment till surgery.
Each case was reviewed from history, clinical examination to biochemical and ultrasound markers to detect their suitability for surgical management.
Outcome of surgery and follow up with histology report completed the procedure.
Results
• 27 out of 30 patients had laparoscopic surgery
• 16 of them had laparoscopic cystectomies and 11 had oophorectomy
• All the laparoscopic procedure had an in-patient stay of around 24 hrs
• 3 procedures that had laparotomy started as a laparoscopy
• One had bleeding from pedicle
Two were too large to be removed through ports and both turned out to be dermoid cysts
Conclusion
Laparoscopic approach is the preferred way for surgery of benign ovarian cysts
Preoperative assessment including RMI can determine the success of laparoscopic surgery
Bigger and solid complex cysts, suggestive of dermoid, has a less success of being removed laparoscopically
All women should be informed about a small but important risk of oophorectomy
These factors should be added in when counselling patients preoperatively
Continued training in laparoscopic surgery amongst junior trainees will improve the outcome in laparoscopic benign ovarian cyst surgery.

P72- Laparoscopic treatment of uterine fibroids: *A comparison of peri-operative outcomes of single verses multiple myomectomy*

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Aims: To compare peri-operative outcomes of laparoscopic myomectomy (LM) for the management of single vs. multiple uterine fibroids.
Methods: Retrospective cohort study of 217 LM performed between 2005 and 2013 at a London teaching hospital.
Results: Length of surgery was significantly greater with multiple myomectomy compared to single myomectomy (128.6 vs 80.5, $p<0.0001$). Multiple myomectomy was associated with increased weight of fibroids (224.1 vs 184.6 $p= 0.0261$), a greater estimated blood loss (333.3 vs 222.8, $p <0.0001$) and an increased use of surgical drains (0.65 vs 0.41, $p = 0.0006$). There was no statistical difference between the rate of surgical complications, drop in haemoglobin, length of hospital stay, resolution of symptoms or patient satisfaction.

Conclusion: Laparoscopic myomectomy for multiple fibroids can be complex and technically difficult surgery. Despite an increase in length of surgery, estimated blood loss and requirement of intraoperative drains, the overall cost effectiveness of a laparoscopic procedure is maintained with no significant increase in hospital stay, requirement of blood transfusions or intraoperative complications. The patient satisfaction and resolution of symptoms is comparable in both groups, suggesting that by an suitably trained surgeon - laparoscopic myomectomy is an appropriate option of management for multiple uterine fibroids.

P73- Learning from Lanarkshire - Informed Consent in Outpatient Hysteroscopy

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The Supreme Court in Montgomery v Lanarkshire Health Board (March 2015) ruled that a pregnant diabetic patient should have been informed of a serious risk of shoulder dystocia and been made aware of her right to choose caesarean section, which would have spared her son from cerebral palsy.
The Lanarkshire judgment updates the law regarding informed consent. Doctors are now obliged to inform patients of serious risks and common less serious complications. The judgment quotes the GMC's **'Good Medical Practice**': "Work in partnership with patients. Listen to, and respond to their concerns and preferences."
The presentation will analyse the implications for informed consent regarding the risk of severe pain during specific stages of outpatient diagnostic and/or operative hysteroscopy: cervical dilation, LA injection, electro-surgery, morcellation.
Using data from the **Outpatient versus inpatient uterine polyp treatment for abnormal uterine bleeding: randomised controlled non-inferiority study, 2015**, the presentation will argue that polypectomy patients should be informed of a) the % risk of severe pain and failure during an outpatient procedure and b) the % risk of uterine perforation during inpatient investigation. It is up to each individual patient to assess the risks and benefits and determine her preferred treatment modality. This is consistent with the NHS Choices Hysteroscopy advice.
Numerous patients' responses to the Daily Mail's 2015 article '**NHS doctors who inflict intimate and agonising surgery on women with NO anaesthetic'** will illustrate how the denial of sufficient pain relief could post-Lanarkshire amount to negligence.

P74- Life threatening anaemia secondary to intracardiac metastatic leiomyomatosis

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Introduction
49 year old Jehovah's witness with a PE on clexane, presented with dyspnoea, per vaginal bleeding and a pelvic mass on examination. She previously had two myomectomies for fibroids. Her haemoglobin was 3 and platelets 25.Our initial impression included that this could be a sarcoma with metastases to the lungs?
Resuscitation was complex without the use of blood and required a multidisciplinary team involving Gynaecology, Haematology and Anaesthetics. Management included: IV immunoglobulins, Methylprednisolone, Romiplostin, Ferrinject, EPO, ferrous sulphate, B12, folic acid and Zoladex. Whilst also being on clexane for her PE.
We diagnosed this mass to be a leiomyomatosis that had metastasised to the heart, it was extending from the IVC to the RA involving the Tricuspid valve.
Definitive surgery was carried out with the gynaecology team carrying out a hysterectomy and the cardiothoracic surgeons removing the intracardiac lesion and repairing the tricuspid valve.
Discussion
This case could be a common scenario that every gynaecology on call doctor may encounter, it illustrates the medical management to treat both severe anaemia and thrombocytopaenia in a Jehovahs' witness, of which there are Leiomyomatosis was first described in 1896 by Birch-Hirschfeld, only 182 cases have been described until 2013. Key factors for suspicion include a lady in her fifth decade of life with a history of having fibroids, even if she has had a hysterectomy or myomectomy as in our case.

P75- Local Anaesthetic for Laparoscopic surgery: Are we doing it right?

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Laparoscopic surgical procedures are established to have quicker recovery, less need for analgesia and better patient experience.
As laparoscopic procedures are getting more popular, various techniques and adjuvant methods have been adopted to enhance experience and recovery of the patient from the procedure.
Injection of local anaesthetic is currently widely practiced technique to supplement postoperative analgesia of patients following laparoscopic surgery, however the technique, timing, dosage and choice of agents vary significantly among different laparoscopy teams.
Also, there is rarely a written local guidance or agreement for the best way of providing local anaesthetic. This is usually given to the local preference agreed between the anesthetist and the surgeon.
The aim of the current study is to provide an evidence-based guidance for the best practice of providing local anaesthetic for laparoscopic surgery. A survey is undertaking place to enquire about views, preferences and techniques for local anaesthetic administration. This included: technique, timing, agent, procedure, counseling and appraisal of evidence. This was very useful to gain insight to the variations of practice and willingness for an evidence based guidance.
A comprehensive literature review was done for clinical studies, systematic reviews and basic science reviews, covering different agents and techniques.
There is a need for an evidence-based guidance to be agreed nationally and internationally for the use of local anaesthetic in laparoscopy. We hope that our study will be a helpful starting frame for any further guideline.

P76- Long term self-reported bladder voiding function following surgery for severe endometriosis

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Aims
Urinary voiding has been noted to be adversely affected in the immediate postoperative period for women undergoing surgery for severe endometriosis. This study aimed to assess the effect of laparoscopic surgery for severe endometriosis on long term self-reported bladder voiding function.
Methods
We retrospectively selected patients with deep endometriosis requiring pararectal dissection who completed both a pre-operative and post-operative (either 6 month, 1 year or 2 year follow-up) BSGE Pelvic Pain Questionnaire. We used patient reported scores from this questionnaire to evaluate urinary voiding following surgery and assess any significant differences by type of surgery.

Results
37/203(18%) patients in our study reported a worsening in score of urinary voiding post-operatively. Of these, 24/37(64%) had a rectovaginal nodule excised, 16/37(43%) underwent bilateral uterosacral ligament excision and 21/37(57%) underwent bilateral ureterolysis. The remaining patients reported either an improvement 28/203(14%) or no overall change 138/203(68%) in voiding function. There was no significant difference noted by type of surgery.
Conclusion
These findings suggest approximately 1/5 women report a worsening in long term bladder voiding function following severe endometriosis surgery. There does not appear to be a correlation between the type of surgery performed and long term self-reported voiding difficulties. However due to the inherent heterogeneity of surgery in these cases, greater numbers of patients may be required to corroborate this. We plan to assess objective urinary voiding tests to further evaluate these important subjective findings.

P77- Measures of success: local experience of an outpatient hysteroscopy service

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Introduction
Outpatient hysteroscopy is an effective and safe procedure which prevents the risks of general anaesthesia and minimises the impact of this investigation on a woman's life.
Primary aim
The success rates of outpatient hysteroscopy.
Secondary aims
The percentage of women where a vaginoscopic approach was used. The percentage of women who had an operative procedure successfully. The reason for any failures. The rates of complications.
Method
This was a retrospective six month audit from September 2014 until the end of February 2015 of women attending the outpatient hysteroscopy clinic at Crawley Hospital. The clinic notes and operative diaries used in the outpatient hysteroscopy clinic were analysed. SPSS was used to input and analyse the data.
Results
96% of women successfully underwent the procedure. 98% of women underwent the procedure vaginoscopically. The commonest reason for failing were cervical stenosis and pain. 2% of women went on to require a hysteroscopic procedure under general anaesthetic. There were no uterine perforations and the rate of complications was low.
Conclusion
The results of this audit are very promising that we are delivering a successful service. However further work on the development of operative procedures such as ablation is needed to reduce the number of women needing day case surgery under general anaesthetic.

P78- Measuring outcome of Laparoscopic hysterectomy in a university hospital

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Introduction
NICE guidance 2007 suggests that safety and efficacy of laparoscopic techniques for hysterectomy appears adequate to support their use, provided that arrangements are in place for consent, audit and clinical governance.
As a teaching university hospital we are moving towards laparoscopic hysterectomy than conventional open surgery.
We are reporting the outcome of laparoscopic hysterectomy in our department.
Methods
34 cases of laparoscopic hysterectomy were reviewed.
Cases were studied from consenting for the procedure to a follow up of 6 weeks postoperative period.
The main outcomes were
• Indication
• Preoperative counselling
• Level of surgeon
• Length of inpatient stay
• Rate of conversion and reason
• Complications (blood loss, visceral injury)
• Return to normal activity at 6 weeks follow up
Result
There were 23 total laparoscopic, 8 laparoscopic assisted vaginal, 1 subtotal laparoscopic and 2 open hysterectomies (converted from TLH)
Main indications were endometriosis and endometrial hyperplasia, fibroids and pelvic pain
Three different consultant teams were reviewed
Two third of procedures were performed by consultants and one third by senior trainees.
Our departmental conversion rate was 2/34, which is 5.9%
There has been no bowel, visceral or major vascular injuries
Rate of bladder and ureteric injury were high (around 3%)
Conclusion
• Proper preoperative counselling regarding urinary tract injuries, rate of conversion, haemorrhage and visceral and vascular injuries are essential
• Early and delayed complications need diagnosis and management aggressively to prevent adverse outcome
• Adequate training is key to the success rate and prevention of complications

P79- Missed opportunities for total laparoscopic hysterectomy

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Introduction
Total laparoscopic hysterectomy (TLH) is associated with less pain, shorter hospital stay and quicker recovery. It is widely advocated to be the preferred method over total abdominal hysterectomy (TAH) when possible, but despite this there are still some women who are not offered the laparoscopic approach.
Aim
To determine the number of women who underwent TAH where TLH may have been possible.
Methods
A retrospective audit on women undergoing TAH from 1st January 2014 to 31st December 2014 for benign disease. Women with suspected/confirmed malignancy or large ovarian masses were excluded.
Results
60 patients were identified who underwent TAH in 2014. Indications for hysterectomy were menorrhagia or pressure symptoms caused by uterine fibroids - 41 patients (68.3%), dysfunctional uterine bleeding - 15 (25%), adenomyosis/pain - 2 (3.3%), recurrent CIN - 1 (1.7%), postmenopausal bleeding - 1 (1.7%).
In 41 patients undergoing TAH for fibroids, 33 cases (80.5%) had a uterine volume of ≥12/40, with a median of 17/40. Of those <12/40 size (n=8), only 2 had known contraindications for TLH (extensive pelvic

adhesions with planned colorectal surgical involvement and uterus too large at laparoscopy).
19 patients had TAH without fibroids, all of these were <12/40 size. 14/19 cases (73.7%) did not have an obvious contraindication for laparoscopy. Contraindications were extensive pelvic and bowel adhesions in 3 cases and patient request for abdominal approach in 2 cases.
Conclusion
20 patients (33.3%) who underwent TAH for benign disease may have been suitable for a laparoscopic approach, this approach should always discussed and considered preoperatively.

P80-*Modified Palmer's Point (MPP)* : *A New Alternative Laparoscopic Initial Entry Point*

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Introduction
Intra-umbilical entry is the traditional laparoscopic initial entry point to establish pneumo-peritoneum used by most gynaecologists.
Laparoscopic surgeon should have an alternative entry point in patients with previous abdominal surgery involving paramedian, midline or paraumbilical incisions. The risk of bowel and omental adhesions to the umbilical region is significantly higher in this group of patients.
Furthermore, after 2 or more failed intra-umbilical entry attempts, very high or low BMI patients, an alternative entry point like Palmer's point or Lee-Huang point should be considered. This minimises complications such as pre-peritoneal insufflation and injury to intra-peritoneal structures.
Palmer's point, an entry point at the mid-clavicular line 3cm below the left subcostal margin, was first described by Raoul Palmer. However, Palmer's point as originally described falls within the anatomical zone of the superior epigastric artery as shown by Saber et al in 2004.
Technique
Start by measuring 8cms laterally from the midline just above the level of the umbilicus (Point A). A second line is drawn vertically from 'Point A' to 3cm short of the left subcostal margin (Point B). 'Point B' is the Modified Palmer's Point (MPP).Entry at this point avoids any potential injury to the superior epigastric artery. MPP entry has an equal puncture:pneumo-peritoneum (P:P) ratio as Palmer's Point.
If significant caudal displacement of umbilicus due to morbid obesity is present, Pelosi re-alignment technique should be done before using MPP.
Conclusion
MPP is a new safe alternative entry point which avoids the superior epigastric artery. It is reliable, accurate and easily reproducible.

P81- Morbidity at Laparoscopic Surgery

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Introduction
The reported incidence of complications of laparoscopic surgery varies between 1-12.5/1000 and is dependent on complexity of the procedure and experience of the operator. We conducted this audit to examine entry techniques, indications & complication rates of laparoscopic surgery in our department.
Methods
This was a retrospective audit conducted at Singleton Hospital, Swansea. Ninety women who had laparoscopic surgery were selected from the hospital database. Case notes were reviewed when additional information was required. Standards for comparison were derived from the BSGE guideline and a recent Cochrane review.
Results
Twenty one percent of women (19/90) had a previous surgery. Veress entry was used in 90% of cases (81/90). In women with previous surgery, the Veress entry was still preferred in 74% of cases (14/19). Pelvic pain was the most common indication. 79% (71/90) were elective procedures. There were 3 cases of haemorrhage from the secondary port site. There were no major complications.
Discussion
It was recognised that the hospital database lacked a means of capturing intra-operative complications. Recommendations were made to capture this information electronically. A new theatre database system was introduced, that records risk factors and complications allowing prospective monitoring of laparoscopic surgical morbidity.
There was a distinct tendency to use the Veress entry. Recommendations were made to make use of other methods of entry. Training to enable surgeons to gain experience in different forms of entry was started.

P82- Mutidisciplinary Meeting for Endometriosis- An approach to optimise Patient outcomes

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Methods
Stockport Endometriosis Centre was accredited by the BSGE in 2013. From its inception a multidisciplinary meeting was set up to have a formal consensus over management and to make individualised patient plans. This was modelled on the Gynaecological Oncology MDT meeting and takes place in a video conferencing room with ability to link various hospitals in the region. Monthly meetings are held with Radiologist, Gynaecological surgeons, Colorectal surgeon and Endometriosis nurse with outcome and discussion documented on a dedicated proforma and communicated to GP and patient. Level of Colorectal/ Urology involvement, Postoperative follow up and imaging are agreed at MDT.
Clearly defined referral criteria such as
Clinical or radiological suspicion of Rectovaginal disease
MRI showing visceral involvement
Lateral disease with distal ureteric involvement
Post hysterectomy disease
Recurrent disease after complex surgery
Post operative discussion to close MDT loop
MDT makes consensus recommendations for treatment modality, further investigations and level of multidisciplinary involvement. Colorectal support is decided as either assistance or joint procedure.
When joint procedure is planned with high probability of bowel resection, preoperative meeting with stoma nurses is arranged and patients are admitted day before surgery in the surgical ward with bowel prep and enhanced recovery pathway.
Results
135 cases discussed over past two years and 54 were categorized as severe endometriosis. With 5 patients currently awaiting surgery 46 patients (94%) were correctly identified with pre operative MRI imaging . 2 cases (4%) were under called on MRI and one patient (2%) had disease volume over diagnosed.

P83- New outpatient hysteroscopy services set up: lessons learned

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Introduction: Our out-patient hysteroscopy clinic is a new service for our trust and we reflect on lessons learnt after the first year of its existence.
Material and Methods: All staff were interviewed regarding lessons learnt over the course of the year with a view to providing a safe and efficient service associated with the highest possible patient satisfaction scores. We performed a 6 month audit of our service and analysed data from a questionnaire given to 74 women after outpatient hysteroscopy.
Results: Clinic protocols for patient assessment, procedure performance and management of potential complications are necessary to ensure an efficient and safe service.
The collection of patient feedback is invaluable in helping to inform and improve the service
Patient leaflets given before attending were beneficial in terms of improving pain and patient satisfaction scores. Reminding patients in their appointment letter of the importance of to reading the leaflet and taking analgesia was found to be helpful.
Patients waiting over 30 minutes pre-procedure increased anxiety levels and increased pain scores. Appropriate timing and duration of appointments improved patient satisfaction rates-
Uniform pregnancy testing in all premenopausal women and deferring procedures in the luteal phase in those without appropriate contraception should be the policy
Strategy for difficult entry cases with extra equipment readily available
Vaginoscopic technique is default approach.
Importance of the same team of nurses familiar with equipment and procedures who can trouble shoot and ensure efficient set up to which help to reduce patient anxiety

P84- Obesity and subfertility: identifying the challenges faced by the subfertility specialist and reproductive surgeon

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Background: Obesity is a well documented risk factor for subfertility; impacting ovulation, eqq quality, implantation and miscarriage rate. Additionally, treatment of this subgroup of patients may pose further challenges in the form of technically difficult procedures, treatment resistance and poor patient engagement.
Methods: we retrospectively evaluated the management of 100 women with a body mass index (BMI) >30kg/m2 attending subfertility clinic, analysing procedure failure and laparoscopic complication rate, ovulation induction and drilling rate, successful weight-loss and pregnancies achieved.
Results: BMI ranged from 30-60kg/m2. Weight loss was achieved in 35 (35%) of patients. 39 (39%) became pregnant and 17 (43%) of those had lost weight. 10 (10%) fell pregnant following advice alone. 67 (67%) of women were anovulatory and 17 (25.4%) of those were resistant to Clomiphene Citrate. 12 (16.4%) required ovarian drilling. 8 (11.9%) of anovulatory women were too overweight to safely commence Clomiphene Citrate. For 6 (6%) women, the cervix could not be visualised and/or cannulised at hysterosalpingogram leading to laparoscopy. 3 (10%) of laparoscopies converted to open laparoscopy using Hassan's method due to difficult entry. 35 (35%) of women were lost to follow up without achieving pregnancy.
Conclusions: Obesity can present many challenges to subfertility treatment including treatment resistance and procedure failure. However, appropriate counselling and support alone may often lead to successful weight loss and pregnancy.

P85- Observational Study of Outpatient Hysteroscopy Outcomes Amongst Postmenopausal Women in a UK District General Hospital

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Introduction
Outpatient hysteroscopy is a well established technique for the investigation of postmenopausal bleeding. The appropriate use of miniature sized hysteroscopes can allow good visualisation of the endometrial cavity, facilitate image guided biopsy, polypectomy and also avoid the risks of general anaesthesia (1,2).
Methods
Retrospective case note review over an 18 month period. Cases identified via hospital information services department.
Results
89/90 patients who had undergone hysteroscopy had postmenopausal bleeding. 81/90 patients had an endometrial thickness above 3mm not on hormone replacement therapy. There was a 97.5% success rate of outpatient hysteroscopy during the sample period. The rate of malignancy identified on histology was 14/90 (15.5%), with 5/14 (35%) highlighting endometrial adenocarcinoma. There was also one case of carcinosarcoma and papillary serous carcinoma during this timeframe.
Conclusions
Our results indicate that most patients had an appropriate endometrial thickness for hysteroscopic assessment. We also found that our rate of malignancies identified from endometrial sampling is comparable with other research. Further investigation is required to study prevalence of rarer malignancies such as carcinosarcoma.
References

- 1. Royal College of Obstetricians and Gynaecologists.Green Top Guideline No.59: Best Practice in Outpatient Hysteroscopy. London:RCOG; 2011
- 2. Marsh F,Kremer C,Duffy S.Delivering an effective outpatient service in gynaecology.A randomised controlled trial analysing the cost of outpatient versus daycase hysteroscopy.BJOG 2004;111:243-8.

P86- 'One Stop' Hysteroscopy Clinic: A Patient Survey

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Objectives:
Identify the percentage of women receiving written information prior to appointment.
Evaluate patient experience and pain scores for scan, hysteroscopy and endometrial biopsy.
Data collection:
Survey given to patients following their visit to the one-stop clinic at Clinic F, Stobhill ACH from June to September 2014. 77 surveys were returned.
Results:
The majority of patients received an information leaflet in advance, found it easy to understand, and felt it made their visit easier.
Patients who underwent hysteroscopy had a mean pain score of 3.1, whereas those who had a biopsy scored 4.3.
Almost all those surveyed (97%) would recommend the service to a friend.
Discussion:
The clinical and economic benefits of a ‘One Stop' clinic for the management of abnormal uterine bleeding are well recognised and in general the procedures involved are well tolerated1. However it is important that all efforts are made to reduce patient anxiety as this can decrease the likelihood of successfully completing all relevant procedures2. Patient information leaflets should therefore be provided to help prepare patients.

The most striking finding of this survey was the overwhelmingly positive impact of the clinic staff on the patient experience.
In conclusion, the vast majority of patients attending the One Stop Clinic at Stobhill have a positive experience and tolerate all necessary procedures well. The support of the dedicated staff is invaluable and significantly contributes to the overall perception of the service.
1. RCOG Green Top Guideline No.59
2. Surg Endosc. 2004 Jul;18(7):1099-104. Epub 2004 May 12

P87- One-stop out-patient hysteroscopy service reduces time to definitive investigation in women referred with Post-menopausal bleeding

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Introduction.
Post-menopausal bleeding (PMB) may signify the presence of endometrial cancer, 10% with PMB under 60 years will have endometrial cancer; rising to 13% over 60 years. The Cancer Reform Strategy (2007) recommends that patients with a suspected cancer should be referred urgently to secondary care and 1st hospital assessment should take place within two weeks.
We sought to determine whether the introduction of a one-stop out-patient hysteroscopy clinic for women with PMB and increased endometrial thickness (ET>4mm) reduced referral to attendance interval.
Methods.
A retrospective audit comparing of a two month period in 2011 following the historical "PMB clinic" model (November 2011-December 2011) and a two month period in 2012 following the "Out-patient hysteroscopy clinic" model (August 2012-September 2012).
Data regarding referral times, scan and clinic visits, and outcomes were drawn from the hospital clinical database.
Results.
In the study period, 89 women attended the "PMB clinic" and 111 in the "Out-patient hysteroscopy clinic" model.
The "PMB Clinic" model had an average referral to assessment interval of 11 days (95% CI 9.75-12.25d). However, patients with increased ET then went on to receive urgent hysteroscopy, as such mean time from referral to definitive investigation was 48.2 days. The "OP hysteroscopy clinic" model had an average referral to assessment interval of 15.4 days (95% CI 11-19.78d), 13.41 days (95% CI 11.58-15.24d) with the exclusion of a 127d outlier.
Conclusion.
The one-stop out-patient hysteroscopy model was associated with a reduced interval from referral to definitive investigation in women PMB.

P88- Opportunistic Bilateral Salpingectomy (OBS) for prevention of ovarian cancer: support for a clinical trial or routine care amongst UK clinicians

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Background
Opportunistic Bilateral Salpingectomy (OBS) is being advocated as an ovarian cancer (OC) prevention strategy at the time of benign gynaecological surgery/tubal ligation for premenopausal women who have completed their family. We report on the prevalence of OBS in current practice and its acceptance amongst UK clinicians.
Methods
An anonymised web-based survey was sent via the RCOG monthly e-newsletter. Baseline characteristics were described using descriptive statistics. Chi-square test was used to compare categorical, Kendal-tau-b test for ordinal and Mann-Whitney test for continuous variables between two groups.
Results
Of the 395/4000(9.9%) respondents, 81% were general obstetricians & gynaecologists and 17% subspecialists. 61% agreed with the tubal hypothesis, 33% performed OBS 'always/most of the time' and 50% supported its introduction. However, 53% thought OBS should 'only' be offered within a clinical trial with 89% willing to support such a study. Lack of data on OC risk reduction(78%), RCT evidence of benefit(76%), and impact on ovarian function(65%) were the leading factors limiting its introduction into routine clinical practice. Maximum support for OBS was at the time of hysterectomy (92%) and tubal ligation (65%). Training implications for self/trainees were highlighted by 21%/49% respectively.
Conclusion
There is broad support in the UK for the principle of OBS with equivalent support for introduction 'only' within a trial/ within clinical practice. The need for prospective evidence to validate its efficacy was highlighted with 89% willing to support a clinical trial. A randomised trial powered on menopause outcomes may be a way forward.

P89- Outpatient hysteroscopy versus ultrasound in abnormal uterine bleeding - should we scope everyone?

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Background : Hysteroscopy is considered the gold standard in diagnosing intrauterine pathology in women presenting with abnormal uterine bleeding (AUB) and post menopausal bleeding (PMB) suggestive of endometrial pathology. Routine practice in our unit is to carry out ultrasound (US) in all women with AUB, only proceeding to hysteroscopy for recurrent episodes, if US suggests pathology or there is high clinical suspicion.
Method : We carried out a prospective audit to compare US, outpatient hysteroscopy findings and final histopathology results in women referred with abnormal uterine bleeding.
Results : 98 patients, aged 36-91 were seen for outpatient hysteroscopy. 75 had PMB, 5 were perimenopausal, 3 had incidental endometrial thickening and 15 had other AUB. 5 had serious pathology detected (3 endometrial hyperplasia; 2 endometrial cancer).
Hysteroscopy revealed intrauterine pathology in 62% of cases, with 1 false negative where the cavity appeared atrophic in the presence of simple hyperplasia on biopsy. US was normal in only 5 women, of whom 2 had benign pathology found at hysteroscopy. The sensitivity of US to detect pathology was 96% but it had only 11% specificity. We found the ultrasound reports had heterogenous descriptions, making it difficult to identify whether serious pathology may or may not be present.
Conclusion : If US is to be considered a useful tool for investigating AUB, stricter guidance should be used for reporting findings, otherwise with a specificity of only 11% it has been proposed that we save the cost of an ultrasound and offer a hysteroscopy to everyone.

P90- Patient feedback on outpatient hysteroscopy in a busy district general hospital – The importance of improving patient care in ambulatory gynaecology

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The RCOG guideline 'Best Practise in Outpatient Hysteroscopy' states that 'all gynaecology units should provide a dedicated outpatient hysteroscopy service to aid management of women with abnormal uterine bleeding'. Recommendations include the use of appropriate facilities outside a formal operating theatre setting, written patient information and consent taking prior to the procedure and ways to decrease pain scores including the use of miniature hysteroscopes, vaginoscopy and encouraging NSAIDs one hour prior to the procedure.
Objectives: To assess patient satisfaction and whether further improvements were required to the service provided in our unit.
Methods: 100 patient satisfaction questionnaires were completed between June 2014 and November 2014.
Results: 100% of patients believed the clinic was easily accessible, staff professional and privacy and dignity maintained. All patients surveyed believed they were given suitable information prior to the procedure with adequate aftercare. 87% received information leaflets prior to the procedure. 84% of patients were waiting for their procedure for less than 30 minutes with 93% finding self -check in kiosks beneficial. 76% had only mild to moderate discomfort. 93% would have outpatient hysteroscopy again, 89% recommending the procedure.
Conclusion: with excellent patient satisfaction, outpatient hysteroscopy should be encouraged in suitable candidates. Further improvements to clinic set up and facilities should be ensured and audited across all units. Information evenings could be arranged for General Practitioners and better dissemination of patient information leaflets prior to outpatient procedures should be encouraged to further improve care and satisfaction.

F91- Patients' perspective of the outpatient hysteroscopy service: a patient satisfaction survey

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Introduction
With a move towards outpatient hysteroscopy as a first line for women it is important to ensure the best experience during this procedure.
Primary aim
The percentage of women who were satisfied with the service and would recommend it to a friend.
Secondary aims
The percentage of women who received information pre procedure. The percentage of women who were satisfied with the reception, staff, and after care. The experience of women during their visit to clinic.
Method
This was a prospective patient survey, given to all patients attending the clinic between December 2013 and February 2014. Qualitative and quantitative data was analysed.
Results
The response rate was 53%. 100% were satisfied with the experience and would recommend to a friend. 100% felt they were treated with dignity and respect. However, only 78% were given pre-procedure information. 8% were not satisfied with the reception area and staff.
Conclusion
The results of this audit are very promising that we are delivering a successful service which is well received by our patients. However it has highlighted areas for continued improvement including pre-procedure information and the welcoming area.

P92- Post Menopausal Endometriosis, A Rare Case Report

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Introduction: Endometriosis is one of the most common gynaecological disorders that affects women in reproductive age and postmenopausal age. It is defined as the abnormal implantation of the glandular epithelium or the endometrial stroma at extrauterine sites. Endometriosis can be misdiagnosed and thus pose a diagnostic predicament. Diagnosis is generally made after Laparoscopy and histological examination.
Case presentation: We present a case of postmenopausal endometriosis in a 41-year-old woman with history of recurrent endometriosis despite undergoing hysterectomy and bilateral salpingoophrectomy (BSO). Postmenopausal endometriosis is uncommon, since after the cessation of menstruation, production of ovarian oestrogen ceases. Although a number of such cases have sporadically been reported the present state of the data is insufficient to permit any appraisal of this and the mechanisms fundamental to the entity have not been thoroughly explained.
Here we discuss about pathophysiology associated with recurrent endometriosis in postmenopausal status, especially the activity of Aromatase P450 enzyme, which is present in the endometriotic tissue itself producing estrogen and hence a positive feedback causing endometriosis in postmenopausal women without any need for external estrogen.
Laparoscopic excision has been recommended for such cases because it reduces the risk of possible malignant transformation in such cases. Administration of aromatase inhibitors has also shown success in suppressing local and exogenous oestrogen, but there is still a need of further research to validate its clinical uses.
Conclusion: Although the reported situation is uncommon, it is vital to be aware of post-menopausal endometriosis because it confers a threat of malignant transformation (0.7-1%).

P93-Prognostic factors that predict success in office endometrial ablation: a cohort study

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The objective of the cohort study was to identify clinical factors that influence the rate of further surgical intervention in women who had endometrial ablation. Prospectively held electronic databases and patient records were scrutinised to obtain historical, examination, investigative and procedural data considered to be potentially predictive of the need for further surgical intervention after endometrial ablation in the office setting. A total of 391 consecutive women were identified who received endometrial ablation in the office setting between July 2005 and December 2012, with an average follow-up of 4.3 years. Univariable and multivariable logistic regression were used to estimate the influence of these variables on prognosis. Factors predictive of further surgical treatment were dysmenorrhea (aOR 4.01; 95% CI 1.63 to 9.91) and a uterine cavity length >9cm OR (aOR 2.65; 95% CI 1.33 to 5.27). In conclusion, dysmenorrhoea before treatment or a uterine cavity length >9cm are associated with the need for further surgical interventions after office endometrial ablation. These findings should help inform clinician and patient decision making when considering treatment options for heavy menstrual bleeding.

P94- Rate of laparoscopic skill acquisition in novice students

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This study aims to investigate the rate of laparoscopic skill acquisition on a simulator to gain insight into the inherency of these skills and potential for their improvement.

Ten first year medical students with laparoscopic experience were timed at five-minute intervals over an hour as they completed a task on a simple laparoscopic simulator. Their initial times were compared with those of obstetrics and gynaecology registrars (ST3+) with no experience of the task, but laparoscopic experience.
The mean recorded initial time of trained registrars (n=9) (191 seconds (range 90-332s)) was significantly shorter than novice students (n=10) (452 seconds, (range 208-787s). The mean time taken for novices to complete the simulated task decreased with time; mean completion time had decreased by 42.18% after 5 minutes of practice, 62.0% after 10 minutes, 74.2% after 25 minutes, and 80.6% after 65 minutes.
The results suggest an overlap between the skills developed through laparoscopic surgery and those required to complete the simulated task as registrars and students were differentiated by skill level. The mean time that novices took to complete the simulated task decreased over time, as a result of increased familiarity with the task's skill requirements such as depth perception and dexterity, and tended towards a plateau. Further work will be needed to see if increased access to these inexpensive simulators for registrars may improve their rate of skill acquisition and if this is transferable to their performance in theatre.

P95- Relation between body mass index and patient outcomes in total laparoscopic hysterectomy: a retrospective observational study in benign and cancer cases

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Increasing numbers of gynaecologists are offering the benefits of laparoscopy to obese patients. Obesity is a risk factor for peri-operative morbidity across surgical specialties. Limited research has been conducted on the effect of obesity on outcomes of major laparoscopic pelvic surgery. Some authors report worsening outcomes in obese women having laparoscopic hysterectomies. Others suggest that complication rates do not increase, but operating times are longer.
Here we report our experience from 252 total laparoscopic hysterectomies performed for both benign conditions and gynaecological cancers, and we compare outcomes among normal, overweight, obese and morbidly obese patients. We used a composite score index calculated on the basis of operating and theatre times, estimated blood loss, length of stay, and number and severity of complications.
The mean BMI of our patients was 30.8 and mean age was 52.9 years. The highest mean composite score was observed in morbidly obese patients. In these patients operating and theatre times were longer. Overweight and obese patients' mean scores were lower than normal weight patients, but statistical analysis failed to show significant differences with the exception of morbid obesity. Regression analysis showed no relationship between the two variables.
Our study has a number of limitations including the inherent bias of a retrospective observational study and a relatively low number of cases. Still, it suggests that meticulous, consistent surgical technique may produce similar outcomes in normal and obese patients having total laparoscopic hysterectomy, with longer operating/theatre times noted only at BMI levels >40.

P96- Review of 6 months data of outpatient hysteroscopy episodes at West Cumberland Hospital; setting up the standards of Care, philosophy of the service and defining outcome measures

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Introduction
Outpatient hysteroscopy is very valuable, particularly in managing postmenopausal bleeding. A failed episode will happen in case of the following;

- inability to proceed with the procedure after premedication
- failure to access the cavity after proceeding
- inability to remove pathology after accessing the cavity
- causing severe pain with unsatisfactory experience

Methods
74 actualised hysteroscopies out of 85 referrals for a newly set outpatient hysteroscopy service were analysed. The practice was supported by a thorough recording of many parameters and outcome measures through prospective audit together with patient satisfaction survey including pain scores. The local anaesthesiology pathway included, if tolerated, patients taking paracetamol and ibuprofen with a light meal before coming to their appointments. The majority on arrival will be given, tramadol, buscupan, ranitidine and cyclizin.The cervix is infiltrated with 4-6 injections of lignospan and instillagel is used for lubrication. If there is pathology then the cervix is dilated to deal with it.
Results
The pick up rate of significant pathology was about 47/74 and the pickup rate of focal pathology was 31/74.There were 7 cancers diagnosed and 6 pre cancers of the endometrium. The cavity was accessed in 100% of cases but there were three failures to remove pathology. Complications were limited; one cervical trauma and 4 cases vagal reaction. Only two cases reported unsatisfactory experience. The procedure's average duration was less than 15min in 85% of the cases
Conclusion
Outpatient hysteroscopy service is feasible, safe with high satisfaction rate and proved valuable in picking up significant pathology. It is essential to define the philosophy of service and reflect its performance through prospective audit.

P97- Review of outcome following hysteroscopic division of intrauterine adhesions or uterine septum

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Background: Hysteroscopic procedures are well tolerated by the patients and effective in treating intrauterine pathology. Systemic reviews did not find any significant difference in reproductive outcome following resection of intrauterine septum and adhesions. However, small observational studies have found beneficial effects.
Method: An observational study of women, who has undergone either resection of intrauterine septum or intrauterine adhesions during the period of 3 years from 2011 till 2014 at University College Hospital, London.
Results: Eleven women were identified for the study. Seven women had intrauterine adhesions following either previous delivery or surgical evacuation of miscarriage. Four women had uterine septum, while two of them had recurrent miscarriages. Following resection of septum and division of adhesion three women needed repeat procedure. Two women had successful pregnancies with IVF treatment and spontaneous conception. Three women had early pregnancy losses and one had failed IVF. Three women who needed repeat procedure are awaited for formation of normal endometrium prior to assisted conception.
Conclusion: There is no significant improvement in fertility outcome following the procedure. This may related to other contributing factor such as age and premature ovarian failure.

P98- Safe entry Techniques; Patient selection and Risk Factors Assessment in Tailoring Individual Patient-Based Laparoscopic approaches

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Minimal access surgery is one of the hall marks of this day and age of gynaecological surgery. Laparoscopy is progressively taking over most of the procedures. Different access techniques have been discussed in more than several occasions. Assessing the individual risk factors of each patient is an absolute necessity in the decision-making process on the best way of gaining safe entry into the abdominal cavity. We aim at reviewing different entry techniques described in the literature and highlighting different individual risk factors that should be taken into consideration when choosing the entry technique. We aim at providing a simple guidance to help safe decision -making on the choice of entry technique to be used. The evidence will be drawn from English-language articles published over the last decade on Medline, Pubmed and the Cochrane data base.

P99- "See & Treat" Satisfaction - Procedural Outpatient Hysteroscopy @ St Richard's Hospital Chichester

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All patients attending the See & Treat outpatient hysteroscopy clinic are asked to complete an anonymous patient satisfaction survey following their appointment to support service improvement and development. All patients are given an information leaflet prior to their appointment about what to expect, pre-procedural analgesia, after care and alternative treatment options including general anaesthetic. Each clinic has a dedicated team with a list of 6-8 patients, each with a half hour slot. Diagnostic and procedural hysteroscopies are performed.
Data from surveys collected from 150 women over 6 months regarding demographics, patient information leaflets, appointment waiting times, pain scores, and experience and satisfaction rates were put onto a spreadsheet and analysed.
93% of women received a patient information leaflet prior to their appointment, of which 98% found this to be 'very informative' or 'informative'. 84% of women reported that the information leaflet relieved their anxieties partially or completely prior to the procedure.
A third of women did not experience any adverse symptoms after the procedure. The most common symptom after the procedure was abdominal cramps, which 47% of women reported. A minority of others experienced shoulder tip pain, nausea and feeling faint.
Overall there was a 99% satisfaction rate with 51% of women reporting their experience was better than expected and 40% as expected. 91% rated their care as excellent.
Analysing patient feedback is imperative to service development and improvement and forms an integral part of our Trust's Patient First initiative.

P100- Size of submucous fibroid and success of TCRF

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Introduction:
Submucous fibroids are associated with menorrhagia and adverse reproductive outcome. Transcervical resection (TCRF) is an effective operation to remove these tumours. We have shown that women with a submucous fibroid >38mm diameter are more likely to require a repeat TCRF. This study aimed to audit our practice and validate this cut off.

Methods:
A retrospective 5-year observational study. Primary outcome measure was complete fibroid resection. Secondary outcome measures were operative fluid deficit, symptom resolution and complication rate.
Results:
During the study period 91 patients underwent TCRF. On ultrasound 74/91 (81%) women had a single fibroid and the median diameter of the largest fibroid was 25mm (15mm IQR). On hysteroscopy 38/78 (49%) fibroids were Type 2, 15/78 (19%) fibroids Type 1 and 25/78 (32%) fibroids Type 0. 50/78 (64%) fibroids were completely resected at a single operation. Median fluid deficit was 275 ml (range 0 – 3000), 3/78 (4%) women received diuretics for suspected fluid overload and 1/78 (1%) required an intrauterine Foley catheter. 63/80 (79%) women had symptom resolution.
37/48 (77%) fibroids <38mm diameter were completely resected at a single operation vs. 3/8 (38%) fibroids ≥38mm (p=0.022). Those that had incomplete resection 7/16 (44%) had a repeat TCRF. 9/16 (56%) had sufficient improvement in symptoms.
Conclusion:
TCRF is an effective and safe procedure that improves symptom. A cut off of 38mm for the preoperative diameter of the largest fibroid can predict need for a repeat TCRF.

P101- Spinal abscess as a complication of ultrasound guided per-vaginal drainage of hydrosalpinx in a patient with a background of Marfan Syndrome

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Introduction
We present an unusual case of spinal abscess as a complication of ultrasound guided per-vaginal drainage of hydrosalpinx.
Case Report
A 56 year old woman with a background of Marfan's syndrome and metallic aortic heart valve underwent an elective repeat transvaginal ultrasound guided drainage of left hydrosalpinx under local anaesthetic.
Following the procedure she became pyrexial with worsening pelvic and back pain and cycling tachycardia. Intravenous antibiotics were initiated for probable pelvic infection. Inflammatory markers were raised with negative blood cultures.
CT scanning identified inflammatory changes within the left greater sciatic foramen, involving the piriformis and gluteus medius muscles, along with a thickened ectatic dural sac extending into the spinal canal suggestive of meningeal inflammation. Subsequent MRI revealed a large intraspinal cystic structure.
Intravenous antibiotic therapy was instigated and an image-guided aspiration performed. Frank pus was drained and E. Coli cultured. Appropriate antibiotics were continued and her symptoms resolved.
Conclusion
Dural ectasia is a common structural feature of Marfan syndrome and under ultrasound visualisation would be indistinguishable from hydrosalpinx.
In reflection of this case our team felt that in cases of connective tissue disease or possible skeletal abnormalities that further imaging must take place prior to ultrasound guided gynaecological procedures to eliminate structural differences.
Inadvertent piercing of dural ectasia is a rare cause of spinal abscess.

P102- Spontaneous resolution of paediatric hydrosalpinx: a case for conservative management

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Background
Hydrosalpinx is a rare cause of abdominal pain in non-sexually active paediatric and adolescent patients, although there are cases documented in the literature. Diagnosis of this presentation can made via ultrasound scan.
Case
A 12-year-old non-sexually active girl presented to the surgical admissions unit with left-sided acute abdominal pain that settled within 24 hours of admission. An ultrasound scan performed by a sonographer suggested the presence of a hydrosalpinx.
A post-discharge follow-up appointment with a consultant paediatric and adolescent gynaecologist demonstrated no symptomology but a repeated ultrasound scan by a second sonographer more clearly revealed continued presence of hydrosalpinx, which had now grown larger.
A decision to operate was made on the principle of risk minimization. The risk of future ovarian torsion is increased in hydrosalpinx, so a decision to operate was made to preserve fertility even in the absence of any troublesome physical symptoms.
Prior to the operation, an MRI was performed to confirm the site of the hydrosalpinx. However, the MRI revealed no tubal masses, suggesting spontaneously resolved hydrosalpinx. A consultant-administered ultrasound scan confirmed no present tubal abnormalities.
Conclusion
This case demonstrates the possibility of spontaneous resolution of paediatric hydrosalpinx demonstrated by repeat imaging, which has not been previously reported. Our recommendation now, based on the same principle of risk minimization mentioned above, is for conservative management of asymptomatic paediatric hydrosalpinx shown on ultrasound, alongside education of the patient and parent/guardian of the presentation of tubal torsion, for which emergency admission and surgery would then be indicated.

P103- Subfertility and Severe Endometriosis: Is endoscopic surgical intervention now the way forward?

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Endometriosis is a leading cause of pelvic pain and subfertility, with a 20-30% incidence in infertile patients. The presence of severe endometriosis (stage III/IV) is widely accepted as negatively impacting fecundity; with rates of conception being reported at almost 0. Whilst gynaecologists are fully aware of this, the decision of how to primarily manage subfertility in this scenario is highly debatable especially in the absence of any other endometriosis related symptoms. There remains a divide with assisted reproduction specialists championing IVF/ICSI as the primary treatment of choice and laparoscopic gynaecologists supporting excision of endometriosis +/- subsequently combining it with an assisted reproductive approach.
In this review we aim to evaluate the conflicting literary evidence, to provide a summary which can help clinicians when counselling patients of the best primary approach for severe endometriosis related sub fertility. Currently there are no published, large, well designed, randomised control trials or meta-analyses comparing the efficacy of all three approaches.
The majority of evidence recognises assisted reproduction as an effective treatment modality which has favourable clinical pregnancy rates, ranging from 32% - 60%. Studies reviewing endoscopic surgery though limited suggest pregnancy rates of 54%. Furthermore when subsequently combined with IVF/ICSI achieving cumulative clinical pregnancy rates of 56%-75%, consistently higher than that achieved by surgery alone or IVF alone in these studies. With evidence also suggesting that the optimal time to conceive is <2 years after surgery by IVF/ICSI and will achieve 2.65 times the pregnancy rate that IVF alone will achieve.

P104- Successful Novasure endometrial ablation following laparoscopic suturing of uterine perforation

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We present a 26 year old para 2 patient with a two year history of dysfunctional uterine bleeding. Management with tranexamic acid, norethisterone and Mirena IUS had failed. Ultrasonography and bloods were normal. After counselling about further management, as she had completed her family she opted to have Novasure ablation for her dysfunctional bleeding and laparoscopic bilateral salpingectomy for permanent contraception.
Following dilatation of the cervix at surgery and insertion of the Novasure device, the device opened to 3.5cm cavity width with no suggestion of perforation; however the cavity integrity assessment failed twice. The procedure was abandoned; we then proceeded with laparoscopy where a small perforation to the uterine fundus was noted. The perforation was closed laparoscopically with two interrupted sutures and bilateral salpingectomy was performed.
A subsequent cavity integrity assessment was successful and Novasure ablation was performed under direct vision.
Conclusion
The Novasure system uses carbon dioxide to verify cavity integrity prior to performing the procedure. Failure of this cavity integrity assessment should raise suspicion of uterine perforation.
As the Novasure is an expensive single use device, our case highlights the options available in conserving resources in cases where uterine perforation occurs and allows the patient to still benefit from an effective day case procedure. This case brings to the fore the value of laparoscopic suturing in gynaecological surgery.
Opting for laparoscopic salpingectomies meant our patient could potentially reduce her risk of ovarian cancer in future, prevent post ablation sterilisation syndrome and achieve permanent contraception.

P105- Surgical Approach for the Benign Ovarian cysts at York Teaching hospital NHS Foundation Trust

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Laparoscopic management of ovarian cyst is well established offering distinct advantages of quick postoperative recovery and reduced cost. Operative laparoscopy should be our primary surgical approach to treat majority of benign ovarian cysts.
Objective:
To assess the surgical approach for the management of benign ovarian cyst at York Teaching Hospital Hospital.
Design:
Retrospective cohort study
Method:
All consecutive women who were operated for ovarian cyst not suspected to be malignant from Sept 2013 to Sept 2014. Total 61 women were identified from the theatre computer record and pathology department. The data was collected from the hospital computer.
Results:
Laparoscopic approach was used in 43 (71%) and 18 (29%) had laparotomy. The mean operation time in the laparoscopy group was 100 minutes (range 40 to 237min) compared to 96 minutes (range 51 to 270 minutes) in the laparotomy group. Mean cyst diameter was 10cm (2 to 31cm) with one 26cm cyst managed laparoscopically. 31 (51%) were managed by cystectomy and 30 (49%) had oophorectomy preferably in women over 45years. In

the laparoscopy group, 43 women were discharged on the same day or following day compared to average 3.5 days in laparotomy group. Two women required second operation by oncologist to complete the operation as the histology suggested borderline and adenocarcinoma. There were no major complications in both groups.

Conclusion:

Laparoscopy should replace laparotomy in the management of benign ovarian cyst.

Further audit is needed in the department to assess the factors affecting the surgical approach.

P106- SURGICAL MANAGEMENT OF OVARIAN CYST IN PREMENOPAUSAL WOMEN

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Aim: To assess our surgical management of premenopausal women with Ovarian cysts.

Method: All Women who underwent surgery for ovarian cyst were identified from the surgical database in a 12 month period (August 2013 to July 2014). A total of 100 women were audited. BSGE/RCOG guidance was used as the auditable standard.

Results: Cysts were managed by laparoscopic surgery in 86% and laparotomy in 14% (4 at caesarean section). Method of surgery was ovarian cystectomy in 52% (45 laparoscopic and 7 open), aspiration in 10%, oophorectomy in 36% and oophorectomy with hysterectomy in 2%.With laparoscopic approach the cyst was removed intact 63%, spill of cystic contents were noted in 37%. However in all the cases the specimen was removed in a contained bag. During open surgery this was 57% and 43% respectively. 50% of the women had midline and lower transverse laparotomies each. There were no significant complications noted. In this cohort 4% women had borderline malignant tumours. Among the 10 open surgery for ovarian cyst/mass 7 benign and 4 were malignant tumours.

The size of the cyst at the time of booking for surgery was <5cm in 36%, 5-7cm in 29% and >7cm in 31%. In 7% this was not available. In our study group only 8 women (13%) <40 years had all the recommended tumour markers 32 women (52%) had atleast 1 other tumour marker.

Recommendation: Aspiration of ovarian cysts should be avoided as this increases recurrence. Women with cyst <5cm should be offered conservative management.

P107- Survey on Laparoscopic Specimen Retrieval among Consultant Gynaecologists in UK

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As laparoscopic surgery involves major surgery through small incisions specimen retrieval can present a challenge, for cosmesis, ease of specimen delivery, pain and potential complications. We thus conducted a survey of consultant laparoscopic surgeon members of the BSGE to determine practices of retrieval of specimen after laparoscopic surgery and the reasons behind the choice of ports sites for retrieval for common laparoscopic procedures

Results

Of the 460 registered consultants 187 (40%) responded to the SurveyMonkeyÔ questionnaire. The most commonly used port for specimen retrieval was umbilical 10mm ports for ectopic pregnancy, ovarian cysts and endometriomas 49%,43% and 43% respectively with no extra port used or existing port extended just for retrieval of specimen.

The second commonest port was suprapubic 10mm ports 35% for ectopic pregnancy,34% for ovarian cysts and 36% for endometriomas.

During the retrieval of specimen most consultants routinely use a retrieval bag.

For laparoscopic myomectomy 84 % of those who performed the procedure would retrieve the specimen by power morcellation, as opposed to a minilaparotomy or posterior colpotomy, 5% of them would perform morcellation in a bag. For laparoscopic subtotal hysterectomy the figure was 93%.

Conclusion

Umbilical port is the most commonly used port for specimen retrieval among UK gynaecologists, most would not insert an extra port just for specimen retrieval. For more complicated procedures despite the recent scare most will still use power morcellation for laparoscopic myomectomy and subtotal hysterectomy.

P108- Temporary psychogenic lower limb paralysis (conversion disorder) following diagnostic laparoscopy for investigation of pelvic pain

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Background:

Functional (psychogenic) loss or weakness of motor functions following hospital admission or surgery is a known conversion disorder. Formerly known as "hysteria", conversion disorder is a rare complication after gynaecological laparoscopies. Patients with conversion disorder tend to regain their sensorimotor functions spontaneously. This is the second case reported with similar complication post-laparoscopy and the first case reported after diagnostic laparoscopy.

Case:

A 25 years old female patient underwent a day case diagnostic laparoscopy under general anaesthesia to investigate pelvic pain. No intra-operative complications were noted. Patient was otherwise fit and healthy. During immediate recovery period, she developed unexplained bilateral lower extremity paralysis. MDT approach was adopted and patient was reviewed by neurology and orthopaedics teams. Diagnostic tests including MRI to exclude any organic aetiology, were all normal. After exclusion of possible organic causes, diagnosis of conversion disorder was made. Patient spontaneously regained full sensorimotor functions around 36 hours after the surgery. Patient was discharged 48 hours post-operative without neurological complication.

Conclusion:

Conversion disorder causes patients to suffer from neurological symptoms, such as numbness, blindness, paralysis, or fits without organic cause. It is thought that symptoms arise in response to stressful situations affecting patient's mental health. The loss of sensorimotor functions as part of conversion syndrome is rare, but still a possible post-operative complication which may be encountered with gynaecological laparoscopies. MDT approach and exclusion of other organic lesions is crucial to establish this diagnosis.

Reference(s):

1.Berhane L, Kurman R, Smith S. Lower extremity paralysis after operative laparoscopy from conversion disorder.A case report.J Reprod.Med1998;43:831-5.(and other references).

P109- The birth of an endoscopic audit tool in a developing country

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PURPOSE: Clinical audit determines gaps between what is and what should be done, revising any ‘lacks' in patient care processes, and is a vital step in quality improvement strategies including accreditation processes.

DESIGN AND METHOD: Laparoscopy and hysteroscopy procedures done at the Aga Khan University Hospital Nairobi in 2013 were audited against a newly designed endoscopic audit tool. Laparoscopy procedures were coded as diagnostic, for ectopic pregnancies, myomectomies, endometriosis, cystectomies, hysterectomies, and other (specify). Hysteroscopies were coded as diagnostic, polyp resection, myoma resection, adhesiolysis, ablation, and other (specify). Possible complications included injury to intraperitoneal and retroperitoneal organs, herniae, pneumoperitoneum related, nerve injury, venous thromboembolism, death, wound infections, and functional compromise after surgery. Electrosurgical sources (monopolar, bipolar, ultrasound) utilized and procedure duration was noted. Hysteroscopic distention fluid was identified and the end deficit recorded.
RESULTS: In 2013, there were 192 laparoscopies and 193 hysteroscopies. Of 286 patient records, 78.3% did not have complete data as per the designed form (except complications). Only 51.6% of the complete data records were by departmental faculty.
LIMITATIONS: Errors in data transcription; incomplete recording of procedure notes.
CONCLUSION AND COMMENTS: The inclusion of this data tool as a necessary and compulsory part of the operation notes for every endoscopic procedure may assist in improving procedure documentation and can provide (e.g. six monthly, or yearly) a valuable resource for audit, which would ultimately lead to higher quality of patient care once the clinical audit cycle is followed through, including feedback to groups as well as individuals.

P110- The impact of 3D Einstein vision laparoscopic technology on Theatre efficiency with surgeons and theatre staff perspective

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Objective
The benefit of the 3D vision in minimal access surgery is well recognised through incorporation in the DaVinci system. However the 3D concept in standard laparoscopy needs to be evaluated and its value demonstrated in the actual theatre environment.
Methods
The 3D system was tried over 4 weeks in laparoscopic gynaecology procedures. Surgeons and theatre staff feedback was collected. Operating time was observed for TLH. The time to close the vault laparoscopically was considered a function of the improved vision and video clips of suturing with 2D and 3D were compared.
Results
There was positive feedback supporting many aspects particularly superior image quality,feasibility and enhanced surgical experience with shorter operating times.For one surgeon's standard technique in performing TLH with intracorporeal suturing the vaginal cuff, the average operative time dropped to 74.17(SD;13.75)mins from 127mins(SD;+/-14.4) and the vault closure to 11.21min(SD;+/-1.85) from 20.82(SD;+/-3.16)min. The unique feature of autonomous warming of the scope was noted to keep the view stable avoiding the frequent interruptions to defog. The sterile sleeve over the scope concept was safe and easy to use and kept the scope ready for the next cases.
Conclusion
The introduction of approved innovations to theatre systems should be tried in a controlled structure where safety, acceptability and impact on productivity are tested and feedback is analysed. Minimal access surgery adopted many developments across its history however the best investment will always be the continuous improvements in optics. 3D vision improved the surgical performance and the increased precision translates into better efficiency.

P111- The Impact of the Presence of a Colorectal Surgeon on the Management and Outcomes of Surgery for Rectal Endometriosis

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For women with extensive endometriosis involving the bowel, multidisciplinary management including a colorectal surgical opinion has become the standard of care. This study examines how the presence of a colorectal surgeon influences the surgical management and post-operative colorectal symptomatology of rectal endometriosis.
The BSGE Endometriosis Centre Database was examined for patients with rectal endometriosis. The presence or absence of a colorectal surgeon upon intraoperative techniques used and patient self-assessment of symptoms, quality of life and effect on daily activities following surgery was examined. Fisher's Exact Test was used to compare treatments and symptomatology with and without a colorectal surgeon present.
426 patients were present in the database, of which 106 (24.9%) had rectal involvement. Teams involving a colorectal surgeon were significantly more likely to perform surgery to the bowel (97.5% vs. 83.3%, $p<0.05$). Scissors were significantly more likely to be used in the presence of a colorectal surgeon (52.4% vs. 21.2%, $p<0.05$) while bipolar diathermy was significantly less likely to be used (4.8% vs. 19.4%, $p<0.05$). There is no significant difference in the patients' symptoms or quality of life between groups following treatment.
The presence of a colorectal surgeon in rectal endometriosis surgery significantly alters surgical treatment, however the ultimate impact of these differences on a patient's overall outcomes remains unclear. It is probable that colorectal surgical involvement is reserved for more extensive cases of rectal endometriosis, and the use of scissors may reflect a need to avoid administration of electrosurgical energy in proximity to the bowel.

P112- The learning curve: do the first few laparoscopic hysterectomies carry a higher risk of complications?

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The increasing trend towards choice of laparoscopic route for hysterectomy in our unit, has led to an expansion in personnel competent in benign gynaecological endoscopy. We conducted an audit of practice at a large teaching hospital to investigate our results for laparoscopic hysterectomies. All patients coded as having had a hysterectomy performed over a three year period between 1/6/11 and 31/5/14 were identified retrospectively from prospectively recorded computerised theatre data. For each case, the indication for hysterectomy, surgical approach, duration of surgery, estimated intra-operative blood loss, duration of stay, complications, need for conversion to open approach, BMI, and previous abdominal surgery were ascertained from computerised casenotes and theatre logs. 1056 patients were identified. Of these, 253 had laparoscopic hysterectomies. The level of experience of the surgeon was noted, and the above data was compared for each successive year during the period of investigation to assess the learning curve within the department. The findings and conclusions will be discussed together with our suggestions for future local policy.

P113- The outcome of laparoscopic assisted vaginal hysterectomy in a district hospital

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Vaginal route is the recommended route for benign indications of hysterectomy. Though laparoscopic assisted vaginal hysterectomy could replace abdominal route where early stage 1 endometrial carcinoma, enlarged uterus, advanced endometriosis and no uterine descent.
We reviewed case-notes for 38 patients who underwent this procedure at STH over 2 year period to check conversion rate, intra-operative and postoperative complication rates, hospital stay, readmission and reoperation rates. About 85% procedures were completed by laparoscopy and conversion rate was 15.7%. Among them 5 patients (11.3%) has had previous abdominal surgery. Half of them (44.7%) underwent peritoneal washing in addition to LAVH+BSO for endometrial carcinoma. Intra-operatively 5 patients (11.3%) bled > 900 ml. The major intra-operative and postoperative complication rate was 2.6% each. None of them has had trauma to bladder, bowel or ureters. No significant differences were seen in intra-operative and postoperative complication rates of patients who were morbidly obese (BMI>35), enlarged uterus (14 weeks) or who underwent additional procedures (bilateral salpingo-oophorectomy, adhesiolysis or prolapse surgery). Majority of them (40%) went home day 2 and only 3 patients (7.9%) needed to stay more than 3 days. None of them was readmitted secondary to surgery complications and reoperation rate was 2.6%. None of the variables studied: age, medical problem, morbidly obesity, enlarged uterus, additional procedures were found to have any association with readmission or reoperation. Conclusion: Laparoscopic assisted vaginal hysterectomy can be performed successfully in most patients with benign indications and early stage of endometrial carcinoma with low complication rate and short hospital stay.

P114- The relationship between pelvic vein incompetence and chronic pelvic pain in women: an evidence synthesis

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Background
Pelvic congestion syndrome (PCS) is described as chronic pelvic pain (CPP) arising from dilated and refluxing pelvic veins, although the causal relationship between pelvic vein incompetence (PVI) and CPP is not established. Percutaneous embolisation is the principal treatment for PCS, with high success rates often cited.
Objectives
To systematically review the association between PVI and CPP and the effectiveness of embolisation for PVI.
Methods
A comprehensive search strategy encompassing various terms for pelvic congestion, pain and embolisation was deployed in 17 bibliographic databases. There was no restriction on study design. Methodological quality was assessed using appropriate tools. The quality and heterogeneity generally precluded meta-analysis so results were described narratively.
Results
We identified six association studies and 21 case series and one poor quality randomised trial of embolisation.
We found the associations between CPP and PVI were generally fairly similar, with three of five studies with sufficient data showing statistically significant associations (odds ratios between 31 and 117). The prevalence of PVI ranged widely, although the majority of women with PVI had CPP. Early substantial relief from pain symptoms was observed in approximately 75% of women undergoing embolisation, which generally increased over time and was sustained.
Conclusions
The quality of data supporting the treatment of PCS is limited and of variable methodological quality. There is some evidence to tentatively support a causative association, but it cannot be categorically stated that PVI is the cause of CPP in women with no other pathology. Embolisation appears to provide symptomatic relief in the majority of women and is safe.

P115- To morcelate or not to morcelate : a case series of 'abnormal' fibroids

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The issues surrounding the use of power morcellation during laparoscopic myomectomy for symptomatic fibroids have caused widespread controversy amongst gynaecologists. Such issues include the risk of severe trauma and seeding of morcellated tissue in the abdominal cavity. One of the most serious concerns is the risk of disseminating occult malignancy such as an inadvertent leiomyosarcoma (LMS); a risk which the FDA has quoted as 1:350 cases. However, the number may be as low as 1:7400 according to research. The incidence of finding 'unexpected' pathology is 1.2% according to one study. Evidently, not all 'unexpected' pathologies will carry a serious prognosis, but distant spread would clearly negatively affect those with LMS.
We present a case series of pre-menopausal women who presented with symptomatic fibroids for which they underwent a myomectomy or a total abdominal hysterectomy. Histological and radiological examination later revealed unexpected pathologies such as LMS and widespread endometrial sarcoma. In two cases, laparoscopic myomectomy was converted to open surgery due to the intra-operative findings and abnormal dissection planes). In both cases power morcellation was not utilised due to open conversion. Following subsequent hysterectomy one patient was shown histologically to have had complete tumour excision the original open myomectomy. The other patient was unfortunately found to have disseminated extra-uterine pelvic spread.
It is unclear whether the risk of dissemination of inadvertent LMS differs with power morcellation versus myomectomy without morcellation (e.g. open myomectomy). Understandably, any disruption of malignant tissue intra-operatively may have significantly poor consequences in those with a sarcoma.

P116- Torted Haematosalpinx: A pain beyond compare

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Torted haematosalpinx is a rare condition with the majority of cases associated with an ovarian torsion; however an isolated torted fallopian tube is very rare with only a few cases being reported in the literature.
We present a case of a 41 year old nulliparous women who attended with severe left iliac fossa pain that had been getting progressively worse over a 2 week period. On examination abdomen was soft with minimal tenderness in left iliac fossa with no rebound or guarding. Bloods and inflammatory markers were normal. She was known to have hydrosalpinx previously but on admission ultrasound there was a haemorrhagic left ovarian cyst.
Patient was taken for Laparoscopy and findings showed a grossly enlarged torted left haemosalpinx. The left fallopian tube had twisted 4 times on itself. The right tube showed hydrosalpinx and otherwise the pelvic anatomy was grossly normal. The patient underwent bilateral salpingectomy and on histology both tubes showed evidence of chronic salpingitis and the left tube showed haemorrhagic infarction. Vaginal swabs were negative and no cause was evident for the salpingitis. Postoperatively the patient had near complete resolution of her pain.

This is a rare cause of sudden onset abdominal pain but should be considered as a potential differential. On review of the literature and from our own scans, imaging for tube torsion has a low sensitivity therefore early laparoscopy would seem to be the most appropriate method of diagnosis in patients presenting with these symptoms and no definitive diagnosis.

P117- Total Laparoscopic hysterectomy (TLH): a Holly Grail or a Harbinger of Trouble?

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Objective. The aim is to analyze indications, outcomes, preoperative and postoperative histopathology results, compare the intraoperative and short-term postoperative complications of laparoscopic hysterectomy and total abdominal hysterectomy and to analyze the shift towards laparoscopic approach in a district general hospital (NHS Lanarkshire).
Methods. Retrospective analysis of 250 cases: 166 cases of total abdominal and 84 cases of total laparoscopic hysterectomies.
Results. Over a period of 16 months we performed 250 total hysterectomies.
2/3 of them (n=166, 66.4%) were TAH and remaining 1/3 (n=84, 33.6%) TLH.
To compare, only 21 TLH were performed over a period of 12 months after introduction of total laparoscopic hysterectomy in our department in 2012.
There were total 3 cases of bowel injury: 1 case during TLH, which required conversion to laparotomy and 2 cases during TAH.
There were 2 cases of bladder injury in patients who underwent TAH; none of the TLH was complicated by bladder or ureteric injury.
There was only 1 re-admission to the hospital after TLH versus 19 re-admissions post TAH.
Majority of the pre-operative histopathology reports were confirmed postoperatively. However, there were nine cases of undiagnosed cancer.
Conclusion. Laparoscopic hysterectomy can be safely done with a low and reasonable complication rate, and a shorter hospital stay.
As experience is gained the operation time, complication rate and hospital stay are decreased.
It is possible to change a practice within settings of a district general hospital. The skills of preforming TLH are reproducible and most gynaecologists can adapt the technique for laparoscopic hysterectomy.

P118- Total Laparoscopic Hysterectomy: incorporating the findings of a retrospective audit for designing an Enhanced Recovery Care Pathway at a tertiary London teaching Hospital

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Objective: The primary objective of the study was to obtain updated surveillance statistics for laparoscopic hysterectomy procedures in order to lay a foundation for designing an enhanced recovery care pathway in our unit.
Methodology: A Retrospective case notes review was taken of all women who underwent Laparoscopic Hysterectomy between May 2012 and May 2014. Demographic data was collected and entered onto MS Excel spreadsheet. Details of surgical procedure including indication, type of surgery, duration of procedure, any intra-operative and/ or post-operative complications and duration of hospital stay were entered electronically for ease of analysis. Any adverse events including unplanned admissions following discharge were recorded.
Results: A total of 38 hysterectomies were performed over these 2 years of which 56 % were performed for benign indications. 84% were completed laparoscopically thus giving a conversion rate of 12.5%. Mean operating time was 199 minutes. 32% of patients were discharged within 48 hours with a mean in-patient stay of 63 hours. Main reasons delaying discharge were postoperative nausea, vomiting, pain, and urinary retention. There were no readmissions following the surgery during this period.
Conclusion: This analysis was crucial to devise a Care Pathway that would ensure patient safety while delivering a high standard of care. With appropriate multi-disciplinary team input and a robust enhanced recovery programme, advanced laparoscopic surgery can be safely performed with improved patient turnover within 36-48 hours, while keeping complications rates at the minimum.
A comprehensive literature review has been undertaken and is presented along with.

P119- Training new hysteroscopists in the setting of a new out-patient hysteroscopy service

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Introduction: The development of ambulatory hysteroscopy requires outpatient procedures to be performed by an experienced clinician. The service requires the clinician not only be able to perform a range of diagnostic and operative procedures but also to perform appropriate risk assessment for each individual patient and modify these technique for difficult cases on a patient who is awake. It is important to establish safe protocols for teaching new hysteroscopists in this setting.
Results: Our 6/12 audit of the out-patient hysteroscopy service showed that hysteroscopy and biopsy could be performed in 90% of women referred with a history of unsuccessful or inadequate pipelle endometrial biopsy.
No perforations in over 1200 OPH procedures performed in our trust. In 40% of cases vaginoscopic approach was used. It took trainees about 48 procedures to learn all techniques including vaginoscopy with both flexible and rigid hysteroscopes. 7% required cervical dilatation and 1% required dilatation under direct vision with micro-hysteroscopy using graspers and scissors. 4% of patient felt sick and 1% had vaso-vagal episodes. 5% of procedures could not be completed.
Conclusion: Although it is possible to shorten pre-clinical training by attending hands on courses, the attainment of skills for outpatient hysteroscopy is individual and competence based. A simple check list would help to guide a new hysteroscopist and will ensure patient safety, while being directly supervised by an experienced clinician

P120-Treating symptomatic uterine fibroids with myomectomy: Current views and practices of consultants

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With women increasingly postponing childbirth into their late thirties and early forties, when fibroids are more numerous and more symptomatic, the number of women seeking uterus-sparing treatments is increasing. With rising education and empowerment, women now demand a wider range of treatments that not only meet their individual needs, but also have an evidence base. Since myomectomy arguably remains the most commonly used treatment, we sought to establish current views and practices concerning myomectomy among consultant gynaecologists in the UK.
Methods: We constructed a 25-stem questionnaire that addressed issues such as the pre-myomectomy use of GnRh analogues (GnRHa) and ulipristal acetate, routine cross-matching of blood, use of cell salvage, any limitations on number of fibroids to be removed at open, laparoscopic and hysteroscopic myomectomy, intraoperative approaches to reduce blood loss etc. This was then emailed to xxx consultant gynaecologists.

Results: To date responses have been obtained from 280 consultants, a response rate of 13%. Open myomectomy is the most common route, with 80% surgeons using GnRHa despite 60% believing that GnRHa destroy tissue planes. Vasopressin is the most common intervention to reduce intraoperative blood loss. The majority of respondents (62%) were not influenced by the size of the fibroids.
Conclusions: We acknowledge the low response rate and therefore interpret our findings with caution. There does not appear to be any major changes in gynaecologists' views and practices regarding myomectomy in recent years, including with regard to the use of GnRHa.

P121- Treatment of caesarean scar ectopic pregnancy at the Royal London Hospital- a series of 19 cases and a literature review

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Caesarean scar pregnancy is rare which means that the treatment options are difficult to evaluate. We present a series of 19 cases of caesarean scar pregnancy, treated at the Royal London Hospital between September 2007 and October 2014. During this time frame our treatment evolved so that the current management combines the use of methotrexate, suction curettage and cervical cerclage. None of the cases experienced any complications.
We also present the results of a literature review examining the reported methods for treating scar pregnancy, including surgical and medical methods and uterine artery embolization.

P122- Ultrasound, Intra-operative and Histological correlation of ovarian cysts in pre-menopausal women

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Preoperative differentiation between the benign and the malignant ovarian cysts is useful in planning their management. Pelvic ultrasound is the most effective way to assess these cysts. The standard treatment for benign cysts is laparoscopic ovarian cystectomy.
Objective:
To evaluate pre operative accuracy of ultrasound assessment of ovarian cysts with laparoscopic findings and histological confirmation.
Methods:
Retrospective analysis of 29 cases of laparoscopic ovarian cystectomies was done. Ultrasound scan, laparoscopic and histological results were compared.
Results:
Preoperative assessment of all the cysts indicated a benign nature resulting in laparoscopic management. Laparoscopic findings correlated with USS in 25/29 (86%) cases resulting in cystectomies. In the remaining 4 cases, intraoperative findings suggested complex nature necessitating oopherectomy and peritoneal cytology.
Histological examination proved that all the cysts were benign. The histology included serous/mucinous cystadenoma, dermoid, endometrioma, luteinised corpus luteal cysts and simple cyst. This showed 100% correlation with USS findings.

P123- Uterine Adhesions: An Iatrogenic Cause of Chronic Pelvic Pain

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Over the past 10 years there has been increasing debate over the closure versus non-closure of peritoneal layers at the time of caesarean section (CS). Historically closure of both layers was advised as this was thought to correctly restore anatomy and reduce the risk of adhesion formation. Current NICE guidance advises against the closure of the peritoneal layers and this now appears to be common practice amongst obstetricians nationwide.
Uterine to abdominal wall adhesions are not a well documented long term complication associated with CS, however with this change in practice, we have increasingly encountered extensive uterine adhesions at the time of laparoscopy in women presenting with pelvic pain with approximately 20 cases in the past 10 years. Although these adhesions cannot definitely be linked to surgical practice it seems credible that the practice of not closing the peritoneum at CS may be a significant contributing factor.
We present one of these cases, resulting in chronic pelvic pain, where extensive uterine to abdominal wall adhesions were found at the time of laparoscopy and adhesiolysis was performed using a harmonic scalpel prior to a total laparoscopic hysterectomy. We also review the literature regarding closure versus non-closure of the peritoneal layers and explore possible long-term surgical implications.

P124- Uterine Artery Embolisation for symptomatic fibroid uterus

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Aim: Determine outcome for women with symptomatic fibroids treated with Uterine Artery Embolisation. Audit the adherance to NICE guidelines: UAE for fibroids.
Materials and methods: A retrospective audit of 54 patients who underwent UAE from 2007-2013.
Results: Steady increase in patients accepting UAE for fibroids over the years with highest number of 42%(23/45) in 2013. The age group was 28-52 years. Out of the 8 nulliparous women, one had a successful pregnancy after a year and another ended with emergency hysterectomy for sepsis.. The commonest presenting symptoms were menorrhagia (63%) and pressure symptoms (14%). More than 75% of patients had UAE within 6 months of referral by a gynaecologist. Day case UAE was offered to patients from December 2011 and so far 80% had successful bilateral UAE as day case. The complication rates were immediate-3.8%, early-1.9% and late-9.6%. 3 patients underwent repeat UAE and 4 ended up with a hysterectomy. Out of the 73% of patients who attended GOPD follow up post procedure; 80% were satisfied with results and 91% had MRI evidence of shrinkage in fibroid size.
Conclusion: UAE is widely accepted treatment for symptomatic fibroids. More and more UAE's have been performed as day case since 2012 with a low re-admission rate (11.5%). Re-intervention rate was comparable to literature.
Recommendation: Ensure UAE leaflets are offered to patients and copy of discharge letter post-UAE are sent to the gynaecologist so that patients are followed up in the GOPD post procedure.

P125- Variables which Influence the Duration of Laparoscopic Hysterectomy

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INTRODUCTION: There are many factors which affect the Duration of laparoscopic Hysterectomies but it is not known which of these factors influence the duration of surgery. The purpose of this study is to analyse the effect of the size of the uterus, previous surgeries and Body mass Index on the duration of 69 laparoscopic hysterectomies performed by one consultant over a period of 2012-2015.
RESULTS: There was a statistically significant overall reduction in the duration of surgery performed by the consultant over the 3.5yr study (p=

0.00642). Factors such as BMI and uterine size also increased the length of surgery although this was not found to be statistically significant. There was only one significant complication in this case series.

CONCLUSION: Laparoscopic hysterectomy is an effective way of performing hysterectomy with minimal complications. There is a positive correlation between the duration of surgery and the uterine size. But perhaps the most important factor is surgeon's experience on its own. Certainly, this is what our case series reflects.

P126- Visual Numeric Endometriosis Scoring system, VNESS. A new endometriosis scoring system aimed to facilitate communication and documentation of disease severity and surgical findings

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Since 1918, at least 17 systems have been proposed for staging, categorization or description of endometriosis. Despite multiple attempts, an easy to use, reproducible, clinically useful and properly validated system is yet to be developed.

The Visual Numeric Endometriosis Scoring System (VNESS) is an attempt to address the shortcomings of previously proposed systems.

VNESS consists of 8 numbers, each between 0-4, representing the severity of endometriosis in each anatomical location in the pelvis, starting from left adnexa, going down to pelvic sidewall, then to the uterosacral complex, then to the uterovesical fold and pouch of Douglas and back up the right side. The intention is that one can easily picture how severe the disease was in different compartments. Examples are provided within the scoring sheet to assist with scoring and a comment box is provided to describe disease outside the pelvis or to provide further description. For example: 313/04/302 – small nodule on terminal ileum.

This presentation reports on the first phase of this project: conceptualization and consultation with experts. Phase two includes two separate studies to assess the inter-rater and intra-rater validity using videotaped procedures. One of these studies has now concluded, showing excellent validity (reported separately) and another is ongoing.

VNESS is a promising system for description of endometriosis severity and can potentially be useful for audit and research purposes by providing a reproducible system that allows benchmarking. It also can be an easy-to-use tool for communication between healthcare professionals and surgical documentation.

P127- Establishing a one-stop ambulatory hysteroscopy service using vaginoscopy at a large Acute Trust - outcomes, learning curve and patient acceptability

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Ambulatory hysteroscopy has been shown to be an efficient, cost-effective and acceptable method of gynaecological diagnostics and therapeutics. Barriers to the implementation of this service may include lack of training and skills, and concerns about patient acceptability. In this presentation we report establishing a successful ambulatory hysteroscopy service using a vaginoscopic approach in a large acute trust.

Data was collected over a 4 year period using a standardised database. Analysis was performed on over 1000 cases. Although the hysteroscopists had not previously had experience of outpatient hysteroscopy or vaginoscopy, success rates were satisfactory from the outset (87%) rising to 98%. Mean pain scores overall were almost identical for diagnostic and operative procedures with no learning curve effect. The pain scores for individual procedures are discussed and evaluated statistically. Also, exploration of the data using data mining techniques is performed.

Feedback taken from patients directly after their procedure showed 89% would elect to have an outpatient procedure again (3% not), with no difference in the first 6 months. A brief discussion of the economic situation surrounding the service will be included.

These data show that establishing a one-stop hysteroscopy service in a large acute trust can be achieved successfully even where clinicians have not previously had experience of vaginoscopy. We recommend the establishment of a similar service in other trusts, such that the economic and patient benefits may become more widespread.

ABSTRACTS

INDEX BY FIRST AUTHOR'S SURNAME	VIDEO POSTER NO
Ali O	FCVP22
Ali O	FCVP29
Ali O	FCVP31
Arambage K, Roman H, Pasquier G, Resch B, Huet E	FCVP28
Asfour V, Banerjee S	FCVP11
Baxter A, Oktaba M	FCVP16
Bean E	FCVP17
Bean E, Doufekas K, Salman G, Cutner A, Jurkovic D	FCVP25
Bharathan R, Gore R, Connell R, Kovoor E	FCVP26
Derpapas A, Khazali S	FCVP14
Derpapas A, Khazali S	FCVP15
Elsayed S, Szetho WZ, O'Sullivan R	FCVP18
Eskandar O, Diyaf A	FCVP6
Fayyad A, Onifade D, Pandeva I	FCVP19
Ghosh D, Aust T	FCVP30
Hardcastle R, Guyer C	FCVP8
Hutchinson L, Sircar S, McMurray D, Datsun K, Allam M	FCVP7
Ibrahim S, Sokolova I, Hawthorn R, Agur W	FCVP5
Ind T, Arshad I, Nobbenhuis M	FCVP4
Ind T, Heath O, Hookway T	FCVP3
Keedwell R, Sreekumar R, Byrne D	FCVP2
Kopeika J, Hamilton J, Kunde K	FCVP23
Kwasnicka LE, Penketh R, Datta S, Bruen E	FCVP20
Ma K, Hemers J, Morris R, Majumder K, Edi-Osagie E	FCVP21
Ma K, Majumder K, Clayton R	FCVP12
Minas V, Ahsraf K	FCVP24
Najdy M, Allam M, Elsapagh K	FCVP27
Nargund A, Griffiths A	FCVP13
Pandey S, Banerjee S	FCVP10
Pandey S, Khazali S	FCVP9
Sreekumar R, Byrne D	FCVP1

INDEX BY FIRST AUTHOR'S SURNAME	POSTER NO
Abdallah K	P98
Abery E, Delchar L	P89
Adishesh M, Kundodyiwa T	P68
Agrawal N, Al-Inizi S	P113
Ali O	P110
Ali O, Moukarram H	P96
Ali R, Mavrelos D, Saridogan E	P100
Ankers D, Coughlin L, Swaminathan A	P85
Arambage K, Visvanathan D	P9
Arshad I, Nath R, Austin C	P74
Asfour V, Fraser G, Banerjee S	P20
Banerjee S, Misra G	P71
Banerjee S, Misra G	P78
Bavananthan T, Lowden H, Arya P, Pathak M	P15
Bean E, Holland T, Cutner A, Saridogan E	P3
Beardmore-Gray A, Holland T, Vashisht A, Saridogan E, Cutner A	P76
Bharathan R, Kovoor E	P44
Bharathan R, McLaren J, Ind T	P59
Bharathan R, Teo L, Farag M, Barton D, Bulmer P	P41
Boland M, Broadbent M	P38
Bolton H, Nosib H, Majmudar T, Abdel-Rahmen H	P57
Borley J, Richardson R	P79
Brewer C, Wilson C, Oxby C	P87
Bullen N, Browning M, Coleman M, Frappell J	P2
Chandrakala Sathish, Matteo De Martino, Stanley Okolo	P92
Clarke J, Taghinejadi N, Craddock C, Holland T, Cohen R, Saridogan E, Cutner A	P111
Cooper N, Gbegbaje M, Ball E, Okaro E	P121
Cowan F, Shirol V, Burnham A	P90
Daniels J, Champaneria R, Shah L, Gupta J, Moss J, Birch J, Middleton L	P114
Datsun K, Elsapagh K, Allam M	P117
Davies M, Pandey S, Banerjee S, Khazali S	P35
Dickson M J	P5
Dickson M J	P37
Dilley J, Lo J	P23
Dodia R, Obura T	P109
Edirisinghe D, Yasmin E	P97
Eskandar O	P1
Eskandar O, Erfan I	P60
Fani Gkrozou, Eve Gaughan, Richard Pyper, Bronwyn Middleton, Natasha Waters	P46
Faraj R, Govinden G, Yeeles H	P26
Gaughan E, Gkrozou F, Middleton B, Pyper R, Waters N	P83
Gelson E, Bolton H, Pradhan A	P45
Gent D, Henderson D,Phillips K, Watson A, Ahmad G	P56
George S, Thomas A, Hale R	P64
George S, Dzyra J, Rai S, Pickersgill A, Llewinsky M	P82
Ghosh D, Rowlands D	P25
Gina Michel, Bronwyn Middleton	P99
Gkrozou F, Gaughan E, Middleton B, Pyper R, Waters N	P119
Gkrozou F, Gaughan E, Pyper R, Middleton B, Waters N	P50
Gnanachandran C, Woollett P, Kimani P, Mylvaganam K, Patel A, Izzat F	P12