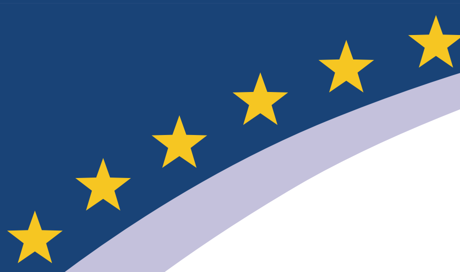

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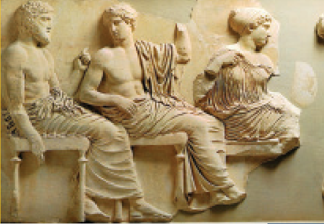

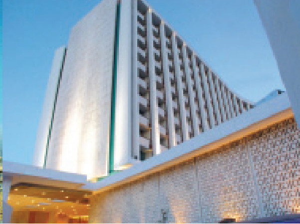

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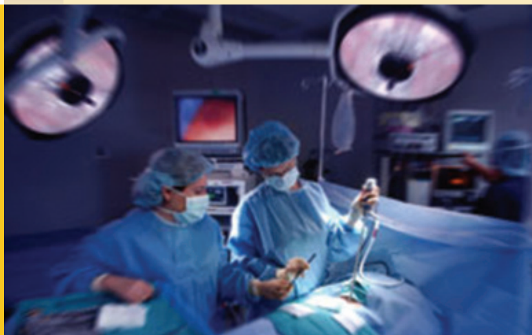

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* Marķa Rita Espejo Catena (1), Marķa Josefa Martķnez Payį (1), José Luis Cruz Simón (1), Amparo Rubio Valverde (2), Angel Ramos Sanvalero (2), Fernando Naranjo de la Puerta (1)
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* Marķa Rita Espejo Catena (1), Marķa Josefa Martķnez Payį (1), José Luis Cruz Simón (1), Amparo Rubio Valverde (2), Angel Ramos Sanvalero (2), Fernando Naranjo de la Puerta (1)
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* Marķa Rita Espejo Catena (1), Marķa Josefa Martķnez Payį (1), José Luķs Cruz Simón (1), Noelia Cuéllar Vargas (2), Francisca Gómez Garcķa (2), Fernando Naranjo de la Puerta (1)
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* Stefanos Chandakas (1), John Erian (1)
(1) Princess Royal University Hospital London, Department of Minimal Access Surgery, London, United Kingdom

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* Stefanos Chandakas (1), Nick Hill (1), John Erian (1)
(1) Princess Royal University Hospital, Depatrment of Minimal Access Surgery, London, United Kingdom

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* Efstratios Fotinos (1), Evagelos Alexopoulos (1), Georgia Dastamani (1), Mixalis Mavroudis (1), Anastasios Ioakimidis (1)
(1) Alexandra Hosrital, Gynecological, Athens, Greece

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* Efstratios Fotinos (1), Evagelos Alexopoulos (1), Anna Georgatou (1), Vasilios Menegos (1), Anastasios Ioakimidis (1)
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(1) Helena Venizelou Hospital Athens, 1st Department of Obstetrics and Gynecology-Hysteroscopy Department. Head: Skolarikos P, Athens, Greece

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* Alexander Georgoulopoulos (1), Horst Steiner (1), Heinrich Wienerroither (1), Alfons Staudach (1)
(1) Paracelsus Medical University, Department for Gynecology and Obstetrics, Salzburg, Austria

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* Shirin Ghazizadeh
Tehran University of Medical Sciences, Imam Khomeini Hospital, Ob/ Gyn Department, Tehran, Iran

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* Grigorios Grimbizis (1), Theodoros Theodoridis (1), Leonidas Zepiridis (1), Kostantinos Dinas (1), Basil Tarlatzis (1), John Bontis (1)
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* Maurizio Guida (1), Giuseppe Acunzo (1), Attilio Di Spiezio Sardo (1), Silvia Bramante (1), Domenico Cirillo (1), Massimiliano Pellicano (1), Stefania Sparice (1), Sergio Frangini (1), Dionisia Canzaniello (1), Carmine Nappi (1)
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* George E. Hilaris (1), Chris K. Payne (2), Joelle Osias (3), Walter Cannon (4), Camran R. Nezhat (5)
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* Anatoly Ischenko (1), Alexandr Slobodenyuk (1), Yuri Chushkov (1), Anvar Shadyev (1)
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* Anatoly Ischenko (1), Elena Kudrina (1), Irina Gadaeva (1), Irina Stanoevich (1)
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* Anatoly Ischenko (1), Irina Stanoevich (1), Elena Kudrina (1), Irina Gadaeva (1)
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* Anatoly Ischenko (1), Alla Bakhvalova (1), Evgenia Fedorova (1), Julia Romadanova (1), Anna Morozova (1), Anvar Shadyev (1)
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(1) Karol Marcinkowski University of Medical Sciences, Division of Infertility and Reproductive Endocrinology, Poznan, Poland

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* Haruka Kakisaka (1), Takashi Murakami (1), Sayaka Saitou (), Yuka Ozawa (1), Tomoko Yoshimoto (1), Yukihiro Terada (1), Nobuo Yaegashi (1), Kunihiro Okamura (1)
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* Hanif Khan
Armed Forces Hospital Lumut, O&G, Lumut, Malaysia

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* Dimitrios Koleskas (1), Luca Sabatini (2), Colin Davis (2)
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* Antonios Kondoravdis (1), Areti Augoulea (1), George Christodoulakos (1), Irene Lambrinoudaki (1), Ioannis Grammatikakis (1), V Tzortziotis (2), George Creatsas (1)
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* Ioannis Korkontzelos (1), Panagiotis Tsirkas (1), Anastasia Zagaliki (1), Athanasios Bartziokas (1), Spyros Lykoudis (1), Christos Akrivis (1), Nikolaos Antoniou (1)
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David Kuzel (1), Dusan Toth (2), Lucie Hrazdirova (1), * Ladislav Hanousek (3), Jan Persin (3), Zuzana Fucikova (1), Marek Mara (1)
(1) Charles University, O/G, Prague, Czech Republic; (2) Clinique St.Germain, O/G, Brive la Gaillarde, France; (3) Regional Hospital, O/G, Pardubice, Czech Republic

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* Antonios Lagadas (1), Konstantinos Giannakopoulos (1), Demetrios Tsarpalis (1), Nikolaos Balakitsas (1), Eleni Toufexi (1)
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* Jenny Lo (1), Andrew Pickersgill (1)
(1) Stepping Hill Hospital, Stockport, United Kingdom

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* Francois Lubbe
Private Practice, Johannesburg, South Africa

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* Artur Ludwin (1), Inga Ludwin (1), Paweł Basta (1), Antoni Basta (1)
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Nikolaos Makris (1), * Konstantinos Kalmantis (1), Elefteria Vomvolaki (1), Joannis xatzipappas (1), Kostas Stefanidis (1), Aris Antsaklis (1)
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* Nikolaos Makris (1), Eleftheria Vomvolaki (1), Konstantinos Kalmantis (1), John Xatzipapas (1), Konstantinos Stefanidis (1), Aristidis Antsaklis (1)
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* Samina Manzoor (1), Funlayo Odejinmi (1)
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* Georgios Maroulis (1), Georgios Galazios (1), Vasilfios Liberis (1), Panagiotis Tsikouras (1), Nikoletta Koutlaki (1)
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* Georgios Maroulis (1), Georgios Galazios (1), Vasileios Liberis (1), Dimitrios Mastrogiannis (1), Panagiotis Tsikouras (1), Nikiletta Koutlaki (1)
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* Elena Martinez (1), Paloma Lobo (1), Leyre Gil (1), Alejandro Pascual (2), Carmen Aviles (1), Gaspar Gonzalez de Merlo (1)
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* Elena Martinez (1), Alvaro Zapico (2), Pedro Fuentes (2), Almudena Grassa (2), Ana Lopez Yague (2), Fuencisla Arnanz (2)
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* Maria Matteo (1), Luigi Nappi (1), Floriana Capodaglio (1), Antonella Angiolillo (1), Luca Lombardi (1), Piergiorgio Rosemberg (1), Pantaleo Greco (1)
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* Ivan Mgaloblishvili (1), Manana Mgaloblishvili (1), Nana Gvazava (1), Ketevan Osidze (1)
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Spyros Milingos (1), * Athanasios Protopapas (1), George Kallipolitis (1), Alexandros Rodolakis (1), Nikolaos Skartados (1), Anthoula Liapi (1), Aris Antsaklis (1)
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* Takashi Murakami (1), Haruka Kakisaka (1), Tomoko Yoshimoto (1), Mitsutoshi Tamura (1), Yukihiro Terada (1), Nobuo Yaegashi (1), Kunihiro Okamura (1)
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* Joseph Nassif (1), Elie Attieh (1), Joseph Abboud (1), Chrystelle Abboud (1)
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* George Pados (1), Dimitris Tsolakidis (1), Dimitris Athanatos (2), Despina Tsatsaroni (2), Dafni Misiaka (2), Athanasios Kalaitzis (2), Eleni Bili (3), Thomas Zaramboukas (4), John Bontis (3)
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Hysteroscopic laser ablation of the endometrium (HLAE) for menorrhagia in a university teaching hospital in the UK

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Minas Paschopoulos (1), * Eleftherios Meridis (2), Vassilios Tanos (3), Lazarow Lavasidis (1), Mattheos Pavlou (), Fani Grozou (1), Stephanie Papatheodorou (3), Geoffrey Trew (2), Evangelos Paraskevaidis ()
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* Maria Josefa Martķnez Payį (1), Maria Rita Espejo Catena (1), Consuelo Aguilar Florit (1), José Emilio Serrano López (1), Agustķn Calvo Juan (1), Fernando G. Naranjo De la Puerta (1)
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Actual perspectives of our experience in the female stress urinary incontinence treatment (SUI)

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* Marķa Josefa Martķnez Payį (1), Maria Rita Espejo Catena (1), Oreto Martķnez Valero (1), Vicenta José Terres Biendicho (1), Fernando G. Naranjo De la Puerta (1)
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* Vicente Payį (1), Juan Gilabert-Estellés (1), Monica Romeu (1), Vicente Diago (1), Jose Julian Rodenas (1), Francisco Coloma (1), Sergio Costa (1), Jose Luis Micó-Chofre (1), Juan Gilabert-Aguilar (1)
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Reproductive outcome following auto-crosslinked hyaluronic acid gel application in infertile patients after laparoscopic myomectomy

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* Litta Pietro (1), Bonora Michela (1), Spiller Elena (1), Fantinato Sara (1), Cosmi Erich (1), Nardelli Giovanni Battista (1)
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Mirko Pjević (1), * Aleksandra Trninić-Pjević (1)
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* Athansios Protopapas (1), Spyros Milingos (1), George Kallipolitis (1), Alexandros Rodolakis (1), Christos Papadimitriou (2), Emmanuel Diakomanolis (1), Aris Antsaklis (1)
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* Hesham Salem
Alexandria Univ., Ob/Gyne, Alexandria, Egypt

P 069
Laparoscopic management of ovarian mature cystic teratomas

* Hesham Salem
Alexandria Univ., Ob/Gyne, Alexandria, Egypt

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* Alessandro Santi (1), Thomas Gyr (2), Markus Eberhard (3), Susanne Lanz (1), Ekkehard Dreher (1), Michael Mueller (1)
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* Nikolaos Skartados (1), Konstantinos Kalmantis (1), Nikolaos Makris (1), Nikolaos Papantoniou (1), Spyros Mesogitis (1), Aris Antsaklis (1)
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* Ioannis Stamatellos (1), Panagiotis Stamatopoulos (1), Ioannis Bontis (1)
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* Ioannis Stamatellos (1), Panagiotis Stamatopoulos (1), Ioannis Bontis (1)
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* Ioannis Stamatellos (1), Eutychia Anagnostou (1), Christos Karidas (2), Aristotelis Apostolidis (1), Panagiotis Stamatopoulos (1), Ioannis Bontis (1)
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* Jacek Szymanski (1), Bogumil Pawel Siekierski (1), Maciej Pliszkiewicz (1)
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Raisa Tchilova (1), * Anatoly Ischenko (1), Vladimir Rafalskiy (2)
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* Theodoros Theodoridis (1), Leonidas Zepiridis (1), Grigorios Grimbizis (1), Dimitrios Vavilis (1), Tryfon Tsalikis (1), John Bontis (1)
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Significance of hysteroscopy in the detection and removal of small endometrial polyps in infertile women with normal menstruation
* Panagiotis Tsikouras (1), Georgios Galazios (1), Vasileios Liberis (1), Asterios Fotos (1), Alexander Tobias Teichmann (2)
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* Panagiotis Tsirkas (1), Ioannis Korkontzelos (1), Christos Akrivis (1), Anastasia Zagaliki (1), Spyros Lykoudis (1), Athanasios Bartziokas (1), Nikolaos Antoniou (1)
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* Gary Ventolini (1), Ran Neiger (1)
(1) Wright State University, OBGYN Department, Dayton, USA

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Successful in vitro fertilization after laparoscopy in a patient with retroperitoneal fibrosis
* Tomoko Yoshimoto (1), Soichi Nakamura (1), Yukihiro Terada (1), Haruka Kakisaka (1), Takashi Murakami (1), Nobuo Yaegashi (1), Kunihiro Okamura (1)
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* Branka Zegura (1), Milan Reljic (1), Igor But (1)
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* Vladimir Zuev (1), Tea Djibladze (1), Andrei Lipman (1), Anvar Shadyev (1)
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* Polat Dursun (1), Mehmet Sakinci (1), Tarik Aksu (1), Hakan Yarali (1)
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* Krzysztof Szyllo (1), Urszula Bartodziej (1), Bogumil Wlodarczyk (1), Jaroslaw Gorski (1)
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Hysteroscopic polypectomy in private practice
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V 002
Laparoscopic operating by torsional ultra sound: from concept to reality in gynaecological laparoscopic surgery
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V 003
Operative therapy of deep infiltrating endometriosis
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V 004
Total laparoscopic hysterectomy using ultrasonic shears
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V 005
Laparoscopic subtotal hysterectomy using ultrasonic shears
* Andrew Kent (1), Peter Barton-Smith (1), Tyrone Carpenter (1)
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Leiomyomas in unusual locations treated laparoscopically
* Dimitrios Mavrelos (1), Manolis Chirakis (1), Antonios Nikoloudakis (1), Kostantinos Mavrelos (1)
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V 007
Total laparoscopic adenomyomectomy of juvenile cystic adenomyoma using hydro-ultrasonographic monitoring
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V 008
Intravaginal sling-plasty in vault prolapse
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V 009
Operative hysteroscopy
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V 010
Diagnostic office hysteroscopy
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V 011
3D-laparoscopy in borderline ovarian tumors
* Piotr Sobiczewski (1), Anna Danska-Bidzinska (), Mariusz Bidzinski ()
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V 012
Paravaginal repair using White's technique
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V 013
Culdolaparoscopy: a multifunctional vaginal port
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O 001

Total laparoscopic hysterectomy in the obese patient

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Objective: A retrospective study was carried out to determine the feasibility and results of using the technique of total laparoscopic hysterectomy in obese patients with a body mass index (BMI)>30.
Methods and Materials: Patients with a BMI>30 were identified in the database who underwent TLH for benign conditions during the period 2000-2003. The patient characteristics were examined. Each woman underwent TLH in a standardized manner. The perioperative and postoperative complications were analysed. The follow-up results were evaluated.
Results: Fifty-eight of a possible 645 patients (9.0%) were identified with a BMI>30 (mean BMI 33.2, range 30.0-49.9). Eight patients had insufficient details to calculate their BMI, and were excluded from the study. The average age of the patients was 48 (±1.03) years. Ninety-three percent of procedures were completed entirely through the laparoscopic route, 2% were subtotal hysterectomies, and 5% were completed vaginally. The average duration of the procedure was 114.4 minutes (±5.0 minutes) and ten operators were involved in these interventions. The mean uterine weight was 294 g (range 45-978 g). There were 2 (3.4%) intraoperative complications and 2 significant (3.4%) postoperative complications. The conversion rate was 7%. After one month, 82.7% of patients were satisfactory at consultation and 1 patient was lost to followup. Problems included persistent pelvic pain (5 patients) and *de novo* urinary incontinence (3 patients).
Conclusion: Our analysis of our procedure and technique in this group of patients showed that performing hysterectomy wholly through the laparoscopic route is feasible, safe, and results in low morbidity.

O 002

Laparoscopic treatment of deep endometriosis without rectum involvement and long-term follow up

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OBJECTIVE: To evaluate the short and long term efficacy of complete laparoscopic excision of deep endometriosis without rectal involvement with opening and partial excision of the vagina
DESIGN: Retrospective analysis of 31 cases with symptomatic extensive disease including involvement of the cul-de-sac and recto-vaginal space.
SETTING: Teaching hospital.
PATIENTS: Thirty-one women (age 19-38 years) with deep pelvic endometriosis.
INTERVENTION: Complete laparoscopic dissection of recto-vaginal space and in block resection of the diseased tissue
MEASUREMENTS AND MAIN RESULTS: No intra-operative complications were observed, 6.5% of the patients presented postoperative fever, 65% were free of analgesic on day 2 postoperative; 38 % had total remission of chronic pain and 22 % were improved; 38% had total remission of dysmenorrhoea and 22% were improved; 45% had total remission of dyspareunia and 25% were improved. Follow up improvement of symptoms was statistically significant and was maintained for five years (p<0.001).
CONCLUSION: Complete surgical resection of deep infiltrative endometriosis with excision of the vagina of the posterior fornix improves life quality with persistence of results for long time in patients not responsive to medical treatment.

O 003

Laparoscopic vs abdominal myomectomy: role on fertility and pregnancy outcome

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BACKGROUND. The role of uterine fibroids in infertility was evaluated indirectly by assessment of fertility after myomectomy in women with unexplained infertility. The pregnancy rate ranged from 45% to 64.3% within 1 year of surgery.
OBJECTIVE. To evaluate the effect of laparoscopic or laparotomic myomectomy on reproductive and pregnancy outcome in women with infertility problems and with intramural myomas without any other known infertility impairment.
METHODS. 72 women with infertility and without male, ovulatory, tubal or infective factors presenting intramural myomas (>3 cm) discovered on pelvic sonography underwent myomecomy by laparoscopy (39) or open surgery (33). Patients were followed for 2 years after surgery with registration of spontaneous conceptions and pregnancy outcome.
RESULTS. In the laparoscopic group we observed 22 pregnancy (53%) vs 17 in the open surgery group (51%). Miscarriage occurred in 4 pregnancies (10%) in the laparoscopic group vs. 4 (12%) in the laparotomic. Though no significant differences were found in reproductive outcome when comparing these two groups there was a positive trend in the laparoscopic group.
CONCLUSION. There are clinical and experimental evidences that intramural myomas may affect fertility. The best surgical approach is still under debate. The site, number and size of the fibroids as well as the expertise of the surgeon along with patient preference may all influence the choice of laparoscopic or open management.

O 004

Extended daycase laparoscopic hysterectomy with the ultrasonic scalpel: an integrated care pathway

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Objective: To show that laparoscopic hysterectomy with UltraCision is a safe, efficient procedure, with high patient satisfaction, performed with realistically obtainable surgical skills.
Design: A prospective observational study set at the Royal Surrey County Hospital. A pathway was developed by consultation between medical and nursing teams. A pathway booklet and patient information sheets were produced. 50 patients have passed through the care pathway. Preoperative diagnoses included menorrhagia, dysmenorrhoea and fibroids. Suitability for laparoscopic hysterectomy was assessed clinically. Preoperatively, patients received counselling from the gynaecologist and clinical nurse specialist. Admission to the short stay surgical unit was on the morning of surgery. Intraoperatively, the procedures were carried out using UltraCision Harmonic scalpel down to the vaginal cuff. The uterus was removed vaginally by simple cervical circumcision and vault suturing. Postoperatively, patients were discharged home the following morning. Follow up was by the gynae clinical nurse specialist. Intraoperative and postoperative data was collected relating to surgery and patient satisfaction.
Results: Mean operating time was 55 minutes. Mean EBL was 155ml. Three patients were readmitted: one patient for a subumbilical abscess and vault haematoma, one for epigastric pain diagnosed as possible acute hepatitis E infection, not related to surgery and one for pyrexia which settled with antibiotics. Three patients were assessed and treated in A&E. Five patients had UTIs, 5 had and 2 had superficial wound infections treated by their GP. Satisfaction scores were consistently high.

Conclusions: Initial results suggest this is a safe and effective approach to hysterectomy.

O 005

Advances in laparoscopic treatment of cervical cancer

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In recent years we have been seeing some considerable advances and changes in the surgical approach to cervical cancer.These advances are influenced by growing evidence that preoperative combination of MRI and metabolic PET-CT scan could make a considerable influence concerning the preoperative staging.Also,there is a growing tendency to select a suitable patients for sentinel nodes dissection and laparovaginal approach, either for radical vaginal trachelectomy or Schauta's radical hysterectomy with laparoscopic pelvic and paraaortic lymphadenectomy.There are on the other hand some patients who benefit from extended parametrial resection at the pelvic side wall and from the resection of bulky lymphnodes.Here as well is the laparoscopic approach advantagious. Judged as a whole, the surgical treatment is individualising and incorporating also the concept of nerve sparing surgery, thus minimalising the sequalae for the bladder, rectal and sexual functions.The laparoscopic approach due to the unparalelled possibility of detail enhancement and also because of electrosurgical advances in recent years has a considerable role to play. This role will be in the future even more enhanced by the use of robotic surgery in the field of oncolaparoscopy. In the lecture the analysis and synthesis of these new developments are presented.

O 006

Hysteroscopic sterilisation: past, present and future

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Laparoscopic sterilisation is associated with not insignificant morbidity and even mortality. Sterilisation via the hysteroscopic route avoids many of the risks of the transabdominal procedure. For more than a century, researchers have attempted to find a safe and effective technique.
Three broad approaches have been investigated: electrosurgical, chemical and mechanical. Diathermy has been discarded due to safety issues; the other two avenues are still being pursued. Quinacrine, of the chemical agents, shows most promise. Introduced in the 1970s in Chile, it does not need expensive hysteroscopic equipment. It has a quoted efficacy of 98% at 2 years and a FDA-approved study commenced in 2000.
Many mechanical devices in the past have been shown to have poor retention rates and effectiveness. The only currently available, licensed product with proven effectiveness is the Essure device. This technique involves the insertion of an inert nickel-titanium coil containing fibrosis-inducing PTFE fibres. Insertion rates have risen to 98%, women report a 96% satisfaction level and complication rates are low. The FDA have just accepted data showing no pregnancies at up to 5 year's usage, with 99.74% of treated women being able to use it for contraception.
There are several devices at various stages of development: the Adiana™ device, Ovion and the Intratubal Ligation Device.
Hysteroscopic sterilisation is now a safe and effective option for women seeking permanent contraception. However, it remains an irreversible procedure and time will tell whether equally-effective, reversible techniques will become available.

O 007

Office hysteroscopy in the treatment of uterine polyps and myomas by using small diameters mechanical and bipolar instruments

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Introduction: we evaluated the benefits of minimally invasive techniques in Office hysteroscopy for the treatment of uterine polyps and myomas.
Methods: from 1995 to 2004 we performed a total of 11513 Office hysteroscopic procedures, of which 6438 were operative procedures (age range 17-81years). 5 Fr. mechanical (scissors and grasping forceps) and bipolar (Versapoint electrode system) instruments were used to treat cervical and endometrial polyps ranging between 0.2 and 3.7 cm, as well as submucosal and partially intramural myomas ranging between 0.5 and 2.2 cm. All precedures have been performed with vaginoscopic approach, without analgesia or anaesthesia, by using both the 5 mm and 4 mm continuous flow operative office hysteroscope. Distention of the uterine cavity was obtained using an electronic suction/irrigation pump.
Results: we have treated a total of 3416 endometrial polyps (2614 by mechanical instruments and 802 by Versapoint electrode), 2288 cervical polyps (2267 by mechanical instruments and 21 by Versapoint electrode), 171 myomas (exclusively by Versapoint electrode), 1625 anatomical impediments, and 804 intrauterine sinechiae (exclusively by mechanical instruments). At follow-up, we observed recurrence of pathology in 361 polyps (7.4%) removed by mechanical instruments, and in 13 polyps (1.6%) removed by Versapoint electrode. Concerning patient compliance, the majority of the patients (86%) accepted the procedure without pain or particular discomfort.
Discussion: improved technology and combination of a new generation small diameter hysteroscope with a bipolar electrode consents to the endoscopic gynaecologist to perform many operative procedures in an Office setting, without significant patient discomfort, with very excellent results in terms of recurrence and persistence of the pathologies.

O 008

One-day laparoscopic surgery: how far can we go?

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OBJECTIVE: The purpose of this study was to analyse our initial 2 years and 5 months experience in one day stay laparoscopic surgery using strict criterious in patients admission and pain control protocols during and after surgery. We purpose to determine the complications, the conversions to laparotomy for technical difficulty, the patients complains and the grade of satisfaction in the day after surgery.
MATERIAL AND METHODS: We reviewed the charts of all one day stay laparoscopic procedures from January 2002 through May 2005 and divided the surgeries into three kinds of procedures, namely tubal ligation, diagnostic laparoscopy and procedure on the adnexa with or without tubal ligation. The parameters evaluated were: number and motives of admissions in the Service of Gynecology, the conversion to laparotomy due to technical difficulty, the need of outpatient assistance after surgery and the grade of satisfaction in the day after the procedure based on phone-call inquirements.
RESULTS: We identified 347 evaluable procedures. Of all these cases, 25(7,20%) appeal to the Unit for medical assistance, with

minimal complains and 21(6,05%) were admitted in Gynecology Service after laparoscopic surgery for several reasons: anaesthetic complications (in number of 15-71,43%), iathrogenic lesion (in number of 4–19,05%) and conversion to laparotomy (in number of 2-9,52%). All patients demonstrated satisfaction during the day after phone-call inquirements.
CONCLUSIONS: Both simple and complex laparoscopic procedures can be performed by a gynaecologic service with a low rate of complications and conversions to laparotomy. The results depend on the correct selection of patients, the efficiency of pain control protocol and the surgical and anesthesic team skills.

O 009

A randomised trial comparing thermal balloon and hysteroscopic endometrial resection for the treatment of menorrhagia

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Objectives: To compare the efficacy and the safety of the Cavaterm thermal balloon ablation with the hysteroscopic endometrial resection.
Design and Methods: In a multicentre trial, 51 women with menorrhagia were randomised to thermal balloon ablation or to hysteroscopic endometrial resection. Operative time, discharge time, complication rate and resumption of normal activities were evaluated for each group. Women completed pre-operative, and 12-month post-operative pictorial charts to assess blood loss and a satisfaction questionnaire. The outcome measures were the amount of uterine bleeding, the women satisfaction and the safety of the procedures.
Results: Amenorrhoea rates at 12 months were 36% and 29% in the Cavaterm and the endometrial resection groups respectively (ns). Both treatments reduced significantly uterine bleeding (median post-operative menstrual blood loss chart <20, range 0-324). The median decrease in menstrual blood loss was significantly higher in women treated by Cavaterm (377, range 108–1300) than in women treated by resection (251, range -82–555) (P=0.002). Two women treated by resection underwent a subsequent hysterectomy for recurrent bleeding. The rate of women reporting good or excellent satisfaction was higher in the Cavaterm group (89%) than in the resection group (79%) at 12 months. Post-operative pain at one hour was significantly higher in women treated by Cavaterm, but operative time, discharge time, and resumption of normal activities were not significantly different between the two groups. There were no major complications in either group.
Conclusions: Thermal balloon ablation was at least as effective and safe as hysteroscopic endometrial resection to treat menorrhagia.

O 010

Daycase laparoscopic subtotal hysterectomies in the UK

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During the last 10 years, minimally invasive surgery has influenced the techniques used in gynaecology, with an overall minimisation of complications and increased patient satisfaction.
OBJECTIVE: To demonstrate the safety, feasibility and morbidity of laparoscopic subtotal hysterectomies in a day-care setting
DESIGN: Retrospective, descriptive, non randomized study
SETTING: Princess Royal University Hospital, London, UK.
METHOD: For the patients who underwent a laparoscopic subtotal hysterectomy in 30 months (November 2002- June 2005), data were collected from medical records on how the intervention was performed, followed for 6 months. A total of 255 subtotal hysterectomies were performed by two surgeons. Indications included 55 (21.6%) cases for endometriosis, 168(66.2%) for menorrhagia, 32(12.05%) for endometrial pathology. Median follow-up was 30 weeks
RESULTS: Duration of operation and of hospital stay, safety (morbidity and mortality), and patient satisfaction were assessed Estimated blood loss was 130 ml (range 50-2000 ml) Intraoperative complications: 0% had significant complications. 0% vascular injuries and 0% nerve or ureter injuries.2,5% had cyclic bleeding. Early postoperative morbidity included 0.5% deep vein thrombosis, 0% pulmonary embolism, 2% bladder infection and dysfunction. The overall complication rate was 1.5%. 1 of them required drainage for intra-abdominal abscess Hospital stay of these 255 patients, 91% were discharged to home the same day with an average length of stay for these patients of 8 hours
CONCLUSION: Laparoscopic subtotal hysterectomy can be safely performed as a day-care procedure.

O 011

Is laparoscopic surgery already the standard in endometrial carcinoma?

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Surgery is the primary therapy of endometrial cancer. As endometrial cancer occurs more frequently in elderly and fatty patients, minimal-invasive surgery seems to be the optimal way to treat the disease. In this lecture, the current literature and the own results of the last hundred patients operated for endometrial cancer by laparoscopy will be reviewed. The objective of the presentation is to convince the audience that in the treatment of the endometrial cancer laparoscopic surgery is not only feasible, but becomes more and more the standard of care.
The outcome of the different treatment modalities, including a total laparoscopic hysterectomy with bilateral salpingo-oophorectomy and, if necessary, a laparoscopic pelvic lymphadenectomy followed or not by a paraaortic lymph node dissection will be compared between patients operated by laparotomy and patients operated by laparoscopy. Furthermore, the follow up of the patients will be compared between the different surgical procedures.
With the appropriate experience in endoscopic surgery, endometrial cancer can be treated by laparoscopy. The operation time as well as the number of recovered lymphnodes is comparable with the historical published results obtained by laparotomy. Although long-term results after laparoscopic treatment of endometrial cancer are still missing, our results and the results from other published studies show that survival and recurrence are similar in both groups.

O 012

Fetoscopic surgery takes its place in modern fetal medicine

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Today, fetoscopy has gained clinical acceptance in fetal medicine hence gynaecologits must be familiar with it. Hardware consists of 1-2mm fiber endoscopes with deported eyepieces, developed with

support of the EC (EUROFOETUS). Obstetrical endoscopy includes surgery on the placenta, umbilical cord and fetal membranes. The most common procedure is laser coagulation of anastomoses for feto-fetal-transfusion-syndrome (FFTS). A recent RCT demonstrated that laser is superior to amniodrainage, improving both survival and neurological morbidity in survivors. Therefore patients should be offered laser as a primary therapy. Fetoscopy is also used to occlude the cord of a non-viable twin in monochorionic multiplets.
We recently showed that sono-endoscopic bipolar coagulation works in a variety of indications and at all gestational ages. Survival is >85% and the only predictor of poor pregnancy and neonatal outcome is PPROM<26wks. A learning curve of 40 cases was shown, mainly reducing PPROM.
Endoscopy is now also used for fetal surgery. We occlude the fetal trachea for severe congenital diaphragmatic hernia, i.e. in case of lethal pulmonary hypoplasia. Tracheal occlusion makes the lung grow to viable levels. Fetuses with isolated CDH, liver herniation and lung-to-head ratio <1.0 are best candidates and operated @26-28 weeks; the balloon is removed @34 weeks, followed by optimal neonatal care. This procedure has improved outcome with 50% in Europe. For both procedures maternal invasiveness and morbidity is minimal. The fetus is the patient that might gain the most of minimal access surgery. EURO TWIN-2-TWIN (QLG1-CT-2002-01632) is supported by the European Commission Directorate Research Fifth Framework Programme.

O 013

Clinical comparison of vaginal hysterectomy, laparoscopically assisted vaginal hysterectomy and total laparoscopic hysterectomy in patients with non-malignant disease of the uterus, tubes and ovaries

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Hysterectomy is one of the most frequent gynecologic surgical procedures. The last two decades are in token of trying to reduce the operative morbidity and to apply the methods of minimally invasive surgery. The effort to reduce the invasivity of the procedure is wending in several directions: a) reduction of the number of hysterectomies, b) development of minimally invasive methods of hysterectomy to classical abdominal hysterectomy (AH): vaginal hysterectomy (VH), laparoscopically assisted vaginal hysterectomy (LAVH) and total laparoscopic hysterectomy (TLH).
Clinical experience and a number of studies demonstrated feasibility and safety of minimally invasive methods of hysterectomy. In spite of the results of few studies that don’t demonstrate definitive benefit of minimally invasive methods compared to abdominal hysterectomy, the clinicians are more and more asked for alternative methods of hysterectomy by better informed patients. That’s why minimally invasive methods of hysterectomy are mostly preferred at present. There is a lot of studies, which compare minimally invasive techniques of hysterectomy to abdominal hysterectomy. However, there is a lack of studies sofar, comparing the minimally invasive procedures to each other. That’s why there is a lack of evidence of the optimum technique of hysterectomy. The aim of our randomised prospective study is to compare of VH, LAVH and TLH in order to assess this evidence. 120 patients were randomly divided into 3 groups – VH, LAVH and TLH, we compared than the number of peroperative and postoperative complications and laboratory parameters after these procedures.

O 014

Embryoscopic evaluation of early missed abortions

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Pathological examinations of the embryos are rarely performed in clinical practice due to inadequate or lack of collection of samples in spontaneous losses; the maceration of non-viable embryos; and the disruption of the tissues at the time of the instrumental or suction curettage. To try to solve these problems, we perform a detailed in situ macroscopic examination of all gestational structures previously to selective biopsies by pre-curettage hysteroembryoscopy.
Chromosomal abnormalities are the main cause of early pregnancy losses. Thus, cytogenetics studies are of interest in first trimester missed abortions. However, their effectiveness may be somewhat limited due to the cell culture failure rate, the potential maternal contamination of the samples obtained by curettage, the possibility of a placental mosaicism and the lack of discrimination in cases of early multiple pregnancy losses.
Direct gestational biopsies obtained by hysteroembryoscopy in early missed abortions are suitable for karyotyping. This approach avoids maternal contamination, identifies placental mosaicisms and allows individual karyotyping in twin missed abortions.
In our studies in early missed abortions the endoscopic appearance of the yolk sac may be helpful in identifying missed abortions due to aneuploidy and the chromosomal analysis of direct hysteroembryoscopic biopsies were more accurate than the curettage karyotypes.
In our opinion, potential indications for karyotyping missed abortions by means of selective hysteroembryoscopic biopsies may include recurrent miscarriages, early losses in pregnancies following assisted reproduction techniques, multiple multizygotic missed abortions, miscarriages in cases of parental balanced translocations, and gestational sacs with ultrasound suspected anomalies.

O 015

Should all endoscopic surgery be performed with routine intra-operative ultrasound ?

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Simultaneous imaging procedures such as x-ray fluoroscopy as well as transvaginal or rectal ultrasound has been reported during the conduct of complex hysteroscopic procedures or in the event of an expected complications intra-operatively.
During the past 4 months 45 hysteroscopies were performed with the use of intra-operative TAS/TVS/TRS.
The combined use of hysteroscopy with transrectal,transvaginal or transabdominal ultrasound provides an excellent opportunity to exploit an additional dimension namely ,depth, in the two-dimensional images seen during these operations. The use of simultaneous ultrasound permits better visualisation of the operative field during procedures for intrauterine adhesions, excision of uterine polyps, resection of submucous fibroids and complete removal of tissues of pregnancy.
It is anticipated that the safety of the operative procedure is increased, and the duration of the procedure typically is shorter.
The use of transrectal or transabdominal ultrasound during the performance of evacuation of products of conception by vacuum aspiration or D&C, also shortens the duration of the procedure and should reduce the incidence of complications such as retention of tissue or perforation.
Selected cases will be presented to illustrate the advantages of this approach.

O 016

Tissue effects of torsional ultrasonic shears and bipolar diathermy: a comparison of findings at histological analysis

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Laparoscopic Operating by Torsional UltraSound(LOTUS)is a new concept in applying ultrasonic energy to cutting and haemostasis which is well suited to gynaecological MAS.We compared the effects on live tissue of LOTUS with a bipolar instrument(Tripol)in ten patients undergoing a traditional open Abdominal hysterectomy and BSO.By random allocaton each case had the round ligament and the infundibilo pelvic ligament divided with the LOTUS on one side,and with Tripol on the contralateral side.The ligaments were then clamped well away from the incision,and excised.The specimens were then reviewed by a specialist gynaecological pathologist,who was blinded as to which instrument had been used on each specimen.Serial sections were cut at 2mm.intervals,and the histological effects compared.
Although the tissue effcts were the main outcome measure,we also recorded the time taken to divide each ligament at surgery,and also made a subjective assesment of the efficacy of haemostasis.

O 017

Hysteroscopic treatment of congenital uterine anomalies

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Congenital uterine malformations are more common than generally recognized. Knowledge concerning their prevalence and varieties is important in recognizing and managing the obstetric and gynecologic complications that may result. In a group of miscellaneous anomalies of the female genital tract septate uterus is the most common followed by bicornuate uterus and arcuate uterus caused by the insufficient resorption of the Müllerian ducts. It seems that malformed uterus and especially septate uterus is not an infertility factor in itself. Retrospective statistical analysis shows that the uterine septa have the worst reproductive outcome with a high incidence of early abortions. But not every patient with a uterine septum suffers from recurrent pregnancy loss. Unicornuate and didelphys uterus have term delivery rates of 45%, and the pregnancy outcome of patients with untreated bicornuate and septate uterus is also poor with term delivery rates of only 40%. Arcuate uterus is associated with a slightly better but still impaired pregnancy outcome with term delivery rates of 65%. Hysteroscopic reconstruction the pear-like shape of the uterine cavity seems to restore an almost normal prognosis for the outcome of womens pregnancies with term delivery rates of 75% and live birth rates of 85%. Therefore hysteroscopic septum dissection can be applied as a therapeutic approach in cases of symptomatic patients but also as a prophylactic procedure in asymptomatic patients in order to improve their chances for a successful delivery. Hyteroscopic dissection of a septum must be performed before starting a fertility treatment. However dissection of a septum does not improve pregnancy rates in infertile patients.

O 018

Comparative study of two techniques of laparoscopic sacrocolpopexy for the treatment of vaginal vault prolapse

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Objectives: To describe two endoscopic techniques for the treatment of vaginal vault prolapse.
Material and Methods: Comparative study of 16 patients with vaginal vault prolapse. 10 patients (A) were treated with combined vaginal and laparoscopic approach. Surgery was initiated vaginally with aperture of vaginal vault and fixation of polypropylene mesh with non-absorbable suture. The mesh was fixed laparoscopically to the promontorium. 6 patients (B) were treated by total laparoscopic approach. The technique includes a dissection of the rectovaginal and the vesicovaginal spaces in order to attach laparoscopically the mesh to the anterior and posterior vagina and to the promontorium.
Results: There were no differences between groups in parity or body mass index. Mean operating time was higher in laparoscopic approach (209,1±12,6 min) in comparison to combined approach (128,0±12,0 min). The were no statistical significant differences in mean decreases in haemoglobin 1,6±0,5 in A versus 1,4±0,6 g/dl in B. The mean length of hospital stay was 3,1±0,6 in I versus 2,8±0,5. Laparoconversion was not performed in any patient and no blood transfusion was required. There was one postoperative thromboflebitis in A and no complications in B. To the date a case of vaginal vault recurrence has been detected in A with no recurrence in B. Follow up shows one case of chronic constipation in A with a high satisfaction rate in both groups.
Conclusion: Laparoscopic approach seems to be better than combined approach for the treatment of vault prolapse in terms of results with low risk of complications.

O 019

Pregnancy outcome after laparoscopic myomectomy

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Objectives: To analyse retrospectively the laparoscopic myomectomies performed in the Hospital Arnau de Vilanova (Valencia). To describe the surgical technique, the complications and the reproductive outcome of these patients.
Design and methods: A total of 144 laparoscopic myomectomies were performed in patients for infertility (68,3%), pelvic pain (10%), pelvic mass (6,7%) or abnormal uterine bleeding (15%). The mean age was 33,8±0,5 years. Previous abdominal surgery was present in 46,5% of patients. Mean follow up was 10,6±1,7months.
Results: In these women a total of 312 myomas were removed laparoscopically. The mean (±SEM) number of fibroids per patient were 1,82±1,2. The mean size of the largest fibroid was 5,37±0,2 cm. Only 27,7% of the patients had a distortion of the uterine cavity and open of endometrial cavity occurred in 7,1% of patients. 61% of the myomas were subserosal and 39 % were intramural. Mean operating time was 119,5±7,2 minutes, mean decreases in haemoglobin was 2,59±0,4 g/dl, and mean length of hospital stay was 40,5±7,5. Laparoconversion was required in 5 patients (3,4%). Postoperative complication rate was 6,2%. Blood transfusion rate was 7%. Average time of analgesia was 24,6±2,7 hours, and average time of intestinal ileus was 23,7±3,1 hours. Pregnancy rate was 32% with a mean delay in conception of 7,6±1,7 months. The recidive rate was 10%. No dehiscence of uterine scar occurred.
Conclusions: Laparoscopic myomectomy is an effective and safe procedure. It has a low risk of complications and it is a valid alternative to the laparotomic approach.

O 020

Prospective comparison of transvaginal ultrasonography, sonohysterography and hysteroscopy in the evaluation of uterine pathology

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AIM: The aim of this blind prospective study was to evaluate the diagnostic accuracy of transvaginal ultrasound (TVS) and sonohysterography for the presence of endometrial pathology. The final diagnosis was established by hysteroscopy.
MATERIAL AND METHODS: Until now (the study is continued)41 patients with subfertility, abnormal uterine bleeding or intrauterine pathology discovered accidentally during routine TVS, were enrolled in this study. All patients underwent TVS and sonohysterography followed by hysteroscopy.
RESULTS: The sensitivity for sonohysterography was 86% and the specificity 72%. The positive and the negative predictive value (PPV and NPV) were 89% and 66% respectively. For TVS, the sensitivity was 53% and the specificity 50%. The positive and the negative predictive value were 85.3% and 33% respectively. Using Fischer's exact test, the sensitivity of sonohysterography is found statistically significantly higher than that of TVS (p=0.01).
CONCLUSION: It seems that sonohysterography is more accurate than TVS in discovering intrauterine pathology. Both TVS and sonohysterography highly predict a positive finding in hysteroscopy (high PPV of both methods). This seems to be extremely useful for the planning of therapeutic approach patient (operative hysteroscopy). On the other hand, the absence of endometrial pathology in TVS cannot exclude the presence of an abnormal finding (extremely low NPV). Sonohysterography seems to be a better diagnostic approach in excluding endometrial pathology (higher NPV than TVS) but not ideal.

O 021

Laparoscopic excision of uterine adenomyomas

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Aim of the study was to mention the existing experience in laparoscopic management of uterine adenomyomas.
Four cases of uterine adenomyomas were managed in a 3 years period.
Two patients were symptomatic having irregular per vaginum bleeding, (metro- or mennorrhagia) and the other two were asymptomatic (the mass was revealed in routine ultrasound scan check). In all but one of them, the mass was singleton. The mean diameter was 5,75cm. All patients underwent laparoscopic myomectomy. Mean operation time was 112 minutes. Surgery was uncomplicated as was post operatative period. The diagnosis was documented with histology.
Although technically difficult, laparoscopic excision of uterine adenomyomas is a feasible option.

O 022

Adenomyosis and interstitial cystitis (IC): concomitant causes of chronic pelvic pain

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This study investigated the possible incidence of Interstitial Cystitis (IC) in patients with chronic pelvic pain and documented adenomyosis. Methods: Participants [287 women] in ongoing study comparing long-term effects of endometrial resection by Nd: YAG laser versus resectoscope were evaluated for CPP. Despite satisfactory treatment outcome for menometrorrhagia, 172/287 (60%) still reported pelvic pain including symptoms of urinary urgency/frequency and dysuria. Surgical pathology reports were reviewed for a diagnosis of adenomyosis. The Pelvic Pain and Urgency/Frequency (PUF) questionnaire, Potassium Sensitivity Test (PST), and cystoscopy with hydrodistention were used to screen patients for IC. Results: Pathology findings confirmed adenomyosis in 48/172 (28%) patients. Of these 48 patients, 32 (67%) had a PUF score of 5 or above (average score, 16.4), suggesting the possibility of IC. Cystoscopy with hydrodistention was performed to visually confirm the presence of IC.Pooling the average of all 3 tests (PUF, PST, and C/H) in all patients with pathology-confirmed adenomyosis, 29/48 (60%) patients had concomitant IC. In patients without adenomyosis, the pooled results of all 3 tests demonstrated that 6/54 (11%) patients had IC. Conclusions: Similar to IC and endometriosis, IC and adenomyosis appear to overlap frequently as the results of this study suggest. The findings also suggest that IC often occurs in women with menometrorrhagia and CPP caused by conditions other than adenomyosis. Adenomyosis may be the cause of excessive uterine bleeding, but the patient's pelvic pain may be originating from the bladder.

O 023

Interest of bipolar operative hysteroscopy

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Monopolar operative hysteroscopy requires the utilization of a non electrolytic liquid of distension that represents a risk of hemodilution in particular during long and difficult myoma resections.
Bipolar operative hysteroscopy must therefore be performed with an electrolytic physiological liquid. This deletes the risk of hemodilution. In bipolar operative hysteroscopy,the saline solution in contact with it heats, boils and liberates vapor bubbles. A vapor pocket is created around the stimulated electrode. These electrical conditions induces a discharge of the electric arc. This important release of energy continues to generate the vapor pocket. The vapor is then ionized to form alasma.The tissue in contact with the plasma pocket is destroyed and very precisely cut.With bipolar current, burn and muscle stimulation risk is cancelled.There are two different bipolar systems: the Versapoint® system and the new bipolar electroresector Olympus®. The first system (Versapoint®) enables the surgeon different types of electrodes and in particular has a electrode allowing vaporization of difficult access myomas.
The high cost of these disposable electrodes limits their use. Nevertheless,we also have to mention the bipolar fibers electrodes allowing to remove small lesions during office hysteroscopy.
Olympus® now offers a new system consisting in a hybrid generator and a bipolar electroresector.Compared to the monopolar resector,it suffices to only change the manipulator.The electrodes are also similar. However, these cheaper electrodes also must be disposed after one utilization. Indications of bipolar operative hyste-

roscopy are the same than in a monopolar one.Because of its elevated cost, it must only be applied for complicated myoma resections.

O 024

Complications and recurrence results after laparoscopic occlusion of uterine artery for symptomatic fibroids

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Aim: To determine the frequency and severity of the complications and fibroid recurrence rate as a result of laparoscopic uterine artery oclussion (LUAO).
Methods: 114 women with symptomatic fibroids were treated using using ultrasonically activated shears, clips or electrosurgery. Retrospective evaluation of complications and recurrence rate was carried out. Each patient had a minimum of a 3 month interval from the procedure at time of analysis. Each complication was categorized using the complication classification developed by the Czech Society Gynecological Endoscopy (CSGE) and a modified set of the American College of Obstetricians and Gynecologists (ACOG).
Results: There were five in-hospital complications and additional 4 adverse events within 3 months, with 8 patients experiencing a peri-operative complication for a rate of 7.1% (95% CI 3.3.-14.4). There were no intra-operative complications and no permanent injuries. Two women required supracervical hysterectomy and myomectomy,respectively, as a result of fibroid necrosis, and one patient had an undiagnosed endometrial stromal sarcoma after 12 months of LUAO. The rate of fibroid recurrence was 6.2% (7 patients). Recurrence free survival interval rate (no clinical failure, no recurrence) at 23.6 month (median) follow-up was 91.2% (CI 84.9-96.5).
Conclusion: The complication and recurrence fibroid rate was low in patients undergoing laparoscopic uterine artery occlusion.

O 025

Indications and limits of laparoscopic myomectomy:

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One of the primary goals of myomectomy is the preservation of the uterus for future fertility. Surgical technique evolved even further with the introduction of microsurgical principles during myomectomy by laparotomy. The introduction of laparoscopic myomectomy (LM) offered the further advantage of microinvasive surgery benefits, and promises to allow the ultimate microsurgical approach to myomectomy in selected cases. Although the procedure is not inherently more difficult than open ones, it is more time consuming and associated with greater blood loss. However, the advantage of LM may outweigh those of open technique, such as less abdominal wall trauma, shorter hospital stay potentially corresponding to a decrease in hospital costs, and more rapid return to normal activity.
Laparoscopic myomectomy is a surgical alternative for women with symptomatic subserosal and intramural fibroids. The indication for this technique is limited. Removal of large fibroids and repair of myometrial defect are challenges to gynecologic laparoscopists, and also the main limitations. Recently, laparoscopic- assisted myomectomy, laparoscopic assisted vaginal myomectomy and combining myomectomy and uterine artery oclussion as an innovative modifications were introduced in order to reduce the blood loss, the time spent at morcellation, but primarily to effect good multi-layered uterine closure following LM.
A well trained laparoscopic surgical team can operate any fibroid. In our experience, as well as reflected by the literature, a consensus gradually emerges that a maximal size of 8-10 cm and total number of fibroids should not exceed 4.

O 026

Combined surgical treatment of full uterine prolapse: first results

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The recurrence rate of vaginal vault prolapse is 3-18% among patients after vaginal hysterectomy, performed in cases of full uterine prolapse.
The new method of combined operative treatment for uterine prolapse was worked out. Main stages of our procedure: cardinal and utero-sacral ligaments are sutured by unabsorbable threads, then they are passed extraperitoneally by special guider and fixed above rectus shealth. These result in high vaginal vault fixation.
From 2004 till now 7 procedures were carried out in cases of full uterine prolapse. Duration of the surgery varied from 60 to 90 minutes. There were no intraoperative complications. Blood loss did not exceed 200ml. No postoperative complications were noted. During this period there were no cases of vaginal vault recurrence.
Thus, we believe our method of surgical treatment is effective in preventing vaginal vault prolapse after vaginal hysterectomy, which were performed in cases of full uterine prolapse.

O 027

Comparison of monopolar and bipolar hysteroscopic surgery

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Introduction: safety and effectiveness between hysteroscopic monopolar and bipolar equipment during resection of fibroids and endometrium.
Materials and methods: 104 premenopausal women with dysfunctional bleedings, fibroids or polyps. Patients are randomized to three arms, monopolar or bipolar (Olympus), or Versapoint (Gynecare) equipment. Safety evaluation includes use of irrigation, deficit and subsequent decline of Se-Na. Additionally operating time, weight of tissue removed and easiness of operation is recorded during operation. Pre- and postoperatively levels of vaginal bleeding, measured by method of Higham(PBAC) and Se-Ferritin are recorded. Follow up at six and twelve months and need for secondary intervention is noted.
Results: Monopolar loop removes 1gram of tissue/min the corresponding values for Bipolar Olympus loop is 1,06 gram and for Versapoint loop 0,57 gram. Fluid consumed in the Versapoint group is higher compared to the two other groups, reflecting increased operating time.
Se-Sodium is lowered from mean 138 mmol/L preoperatively to mean 133 mmol/L postoperatively in the monopolar group, reflecting use of none Sodium containing fluid compared to the no significantly reduction in the bipolar groups.
Conclusion: Se- Na is stable during bipolar surgery. The loop size and cutting quality is important, versapoint needs more time, and consequently increased fluid deficit compared to both monopolar and bipolar Olympus equipment to remove the same amount of tissue.

O 028

Conservative treatment of fibroids
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Uterine fibroids are the most common solid pelvic tumors in women. Although many fibroids seem to cause no symptoms, for some women they can have serious adverse effects and impact on quality of life. Common symptoms associated with fibroids include abnormal uterine bleeding, pelvic pressure and reproductive dysfunction. The past decade has witnessed highly sophisticated diagnostic and therapeutic technology for fibroids.
The tools currently at our disposal permit greater management flexibility; which must be tailored to the individual clinical situation
Nonsurgical treatments include medical therapy and treatments interfering with the blood supply to the uterus or the fibroid, of the latest introduced is uterine artery embolization performed by interventional radiologist and laparoscopic uterine occlusion by the gynaecologist. Even simpler is the non incision temporary uterine clamp directed with Doppler and placed in the side fornix's in the vagina.

O 029

Porcine dermal collagen graft in cystocele, rectocele and enterocele repair
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The aim of this study was to evaluate the efficacy and safety of porcine dermal collagen implant in anterior and posterior vaginal wall prolapses.
Eighty four patients with anterior and posterior vaginal wall prolapses and those with enteroceles had been recruited up to March 2005 in this report. Collagen layer (Pelvicol and Permacol) was inserted under the vaginal skin in an anterior (n=46), posterior (n=19) or anterior and posterior (n=19) position as a part of their repairs. The follow up period had been between 1 and 24 months.
The results to date show an aesthetically acceptable implant material that appears to provide a firm support to the vaginal repairs. There were no observed cases of expulsion, shrinkage and dyspareunia. Two patients had lateral defect-type cystoceles.
Porcine skin collagen implants lead to a very pleasing result after conclusion of the healing process. Long term results have to be evaluated concerning the efficacy of this method.

O 030

Total laparoscopic hysterectomy
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Laparoscopic access to hysterectomy has gained its place as a routine method. The variety of available instrumentation to achieve coagulation and cutting is vast and few studies has been done to support any specific choice. The experience of using ultrasound energy for coagulation and cutting is ten years old and during the time the instrumentation has been refined several times. The benefits are safety and simplicity. The instrumentation, which is needed for laparoscopic hysterectomy, is reduced to ultrasound devise, a suction-irrigation and one grasper. The operation can be accomplished by one 5mm operation port in the midline (optic in the belly). The operation is fast, in most cases less than one hour. With accurate patient selection the peri- and postoperative complication rate is 6.4%. The frquence of long term vaginal vault prolapse is 1.1% and the average time for the occurrance of prolapse after the operation is 40 months. Laparoscopic hysterectomy with ultrasound energy is a safe, simple and fast method with good long tern results.

O 031

Bladeless trocars used for direct insertion in laparoscopic procedures
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Objective: The technical aspects of gaining access to the peritoneal cavity are diverse and continue to court controversy. A prospective review of laparoscopic cases using two closed access techniques is described: a bladeless trocar for direct access and the closed Veress needle technique. The safety of direct bladeless trocar insertion for pneumoperitoneum creation was assessed by comparing with the Veress needle technique.
Patients and Methods: All patients underwent gynaecological laparoscopic procedures by the author. Veress needle entry was done in the usual manner whereas the bladeless trocar technique involved insertion of a 12 mm trocar using a continuous twisting motion. Evaluation of technique and device was done with regard to simplicity of access, carbon dioxide leakage, access time, and complications.
Results: The time taken for insufflation of the cavity and scope entry was significantly shorter in the direct bladeless trocar entry. There were no visceral or vascular injuries noted in both groups, but CO2 leakage and subcutaneous insufflation of gas experienced in the Veress needle group resulted in lengthened operative times.
Conclusion: The bladeless trocar is an established, safe alternative to blind access for gynaecological laparoscopy. The technique is simple and rapid and avoids some of the difficulties encountered using the Veress needle. This method provides surgeons an easy and efficient option for peritoneal cavity access. The bladeless trocar is favoured because it is designed to avoid all sharp instrumentation and offers superior seal and mobility, as well as expeditious and easy abdominal access.

O 032

Thermal balloon ablation
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The purpose of this study was to assess efficacy, safety and patient satisfaction after thermal balloon ablation in patients with abnormal uterine bleeding.
Sixty seven women who underwent thermal balloon ablation in our department had a follow up personal interview. Patients were asked about postprocedural menstrual blood pattern and patient satisfaction. The follow up was 24 months for the majority of patients and a personal interview was obtained for all patients.
After the last follow up, 91% of patients were considered to have had successful treatment (Amenorrhea 29%, Hypomenorrhea 28,5%, Eumenorrhea 33,5%) and 9% failed treatment (Menorrhagia 6% and Hysterectomy 3%). Assessment of the level of satisfaction was 95%.
Thermal balloon ablation is a safe and efficient method for the treatment of abnormal uterine bleeding with high percentage of patient satisfaction.

O 033

Endoscopic treatment of deep infiltrating endometriosis (DIE) involving the bladder and rectosigmoid colon

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Design: To evaluate the results of endoscopic surgery in patients with DIE involving the bladder and the rectosigmoid.
Setting: Univ. tertiary referring centre, Oslo Norway
Material: 24 patients beeing treated for DIE with laparoscopic techiques from Jan 2004-May 2005
Interventions: Individualized surgical treatment with removal of DIE in all patients; in addition, bladder resection was performed in 5 patients, colorectal resections in 8 patients.
Measurements: preoperative symptoms and workout, staging, and surgical procedures were recorded, as well as follow-up of the patients.
Results: All patients had DIE. We were able to remove all detectable endometriosis through the endoscopic procedures; in 11 patients only by removing the lesion by dissection, in the other 13 patients by simoultaneously resection of the bladder and/or the recosigmoid. There were two laparoconversions and one temporary loop ileostomy. No major per-or postoperative complications were recorded. Follow-up results wil be presented.

O 034

A new classification and a new technique in hysteroscopic myomectomy

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To develop a new pre-operative classification of submucous fibroids for evaluating the viability and the degree of difficulty of a hysteroscopic myomectomy. The new classification was based on the subjective analysis of the parameters that make surgery more difficult. Four criteria were considered: the penetration of the nodule into the myometrium, the extension of the base of the nodule with respect to the wall of the uterus, the size of the nodule and its topography. Each parameter has score 0 to 2. When the fibroid is on the lateral wall, an extra point is added. Therefore 3 groups will be made, I, II and III. Group I it's possible, Group II it will be difficult and Group III it's impossible the hysteroscopic myomectomy.
New technique in hysteroscopic myomectomy will be presented using direct mobilization of the fibroids with less energy and low risk.

O 035

Hysteroscopic resection of symptomatic and asymptomatic endometrial polyps

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Objectives: Endometrial polyps occur in symptomatic and asymptomatic women. The aim of this study was to achieve knowledge of the malignant potential of endometrial polyps in symptomatic as well as asymptomatic patients.
Study design: A retrospective registration of all patients who underwent hysteroscopic resection of endometrial polyps in our department from January 1st 2001 to March 1st 2005 was performed. Age, menopausal status, presence or absence of symptoms, any use of hormonal medication as well as histological diagnosis, complications and eventual repeated surgery were documented.
Results: 411 patients underwent hysteroscopic resection of endometrial polyps. 129 patients (31,4 %) had no symptoms. In eleven patients (2,7 %), the histological examination showed malignant endometrial polyp and in three patients (0,7 %) atypical polyp. Five of the fourteen patients with malignant or atypical endometrial polyp had no symptoms.
Conclusion: With a incidence of malignancy of 2,7 % and atypical hyperplasia of 0,7 %, endometrial polyps should be removed by hysteroscopic resection, regardless of age and symptoms.

O 036

How to avoid, identify and manage complications performing pelvic endoscopic surgery

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Gynaecological endoscopic surgery is now well into its second decade and the initial high complication rates hopefully decreasing rapidly. However, less than 10% of hysterectomies are being performed with laparoscopic assistance in the United States, which means that by far the majority of gynaecologists have not been introduced to, or practice advanced pelvic endoscopic surgery. Inexperienced gynaecologists today should not have the same high complication rate as the pioneers of the early nineties because of the availability of experienced preceptors, colleagues and assistants, not even to mention the availability of learning opportunities. Conferences, live surgery, workshops and high-tech (live surgery) teaching material are freely available.
This presentation addresses the basic principles of pelvic endoscopic surgery focusing on complication prevention as well as the diagnosis and management of complications in advanced surgery utilising video demonstrations.

O 037

Hysteroscopic method of intramural and submucosal myoma enucleation in its entirety by applying a controversial technique of electroresection with the loop electrode working forward

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Objective:Presentation and value assessment of enucleation method of submucosal and intramural myomas in its entirety by applying technique of electroresection with loop electrode workingforward.Design:Study group:54 women with performed enucleation of myoma by hysteroscopy with loop electrode working forward.Control group:62 women with myomectomy performed by conventional electroresection.Hysteroscopic myomectomy was performed when myomas had any contact with uterine cavity, free margin of myometrium over myoma was>4mm,its size was<5cm.Some of the operations were performed with assisted transrectal ultrasonography.In both group characterizing parameters of course of hysteroscopic procedures, amount of intra- and postoperative complications and anatomical results after procedures were compared.Chi2 and student test were used for statistical analysis.Results:In study group no significant intra- and postoperative complications were observed.In control group 2(3,2%)cases of uterine perforation and 1(1,6%)case of overload system were noticed.Mean time of total procedure was shorter by applying of enucleation technique(23vs34min) and also total usage of medium and negative medium balance were smaller.Statistical significant differences concerned anatomical results assessed

ultrasonographycally after operation:in study group no totally remove the myoma was stated in 3(5,5%)cases, vs.11(17,7%)cases in control Group.These differences concerned mainly intramural and submucosal myomas in stage G2 by ESH.
Conclusions:Use of hysteroscopic enucleation technique of myoma in its entirety allows to shorten the time of procedure and real time of uterus irrigation by medium. Use of loop electrode working forward facilitates complete enucleation of myoma within the limits its pseudocapsule without increasing risk of uterine wall perforation and other complications when operator is technically proficient and operating qualification was adequate.

O 038

Reduction of postoperative adhesions following laparoscopic myomectomy using an hyaluronic acid

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Following myomectomy postoperative adhesions occur in many patients with adverse effects on fertility. This study investigated the applicability, safety, and efficacy of an autocrosslinked hyaluronan gel in preventing adhesion formation after laparoscopic myomectomy. Fifty-two patients aged 22-42 years, undergoing surgery at four centres, were randomly allocated to receive either the gel or no adhesion prevention. The incidence and severity of postoperative adhesions were assessed laparoscopically after 12-14 weeks in a blinded fashion. A higher proportion of patients receiving the gel were free from adhesions (13/21, 62%) compared to control patients (9/22, 41%). In subjects undergoing myomectomy without concomitant surgery, the adhesion-free patients were 8/12 (67%) and 4/11 (36%), in the gel and control groups, respectively, with a significant difference in the mean severity scores (1.5 and 2.7, respectively; $p<0.05$). In subjects without uterine adhesions before myomectomy, 12/18 (67%) and 8/20 (40%) of patients were adhesion-free, respectively, with a significant difference in the severity of uterine adhesions (0.5 and 0.9; $p=0.05$). The results confirm that adhesions occur in many patients following laparoscopic myomectomy and suggest that the autocrosslinked hyaluronan gel has a favourable safety profile and has efficacious anti-adhesive action in these patients.

O 039

Adhesion prevention with a polyethylene glycol in fibroid resection

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Introduction: Adhesion prevention in gynaecologic endoscopic surgery remains a crucial prerequisite which we should all strive for. In the present randomized study a polyethylene glycol gel called Adhibit from Angiotech was tested in 45 patients with uterine fibroids for its adhesion preventive effect.
Material and Methods: Randomized trial to prove the efficacy of "Adhibit". Forty-five patients underwent a fibroidectomy via laparoscopy. At the end of surgery an adhesion preventive gel was sprayed over the surgical site. Six to twelve weeks later, a second-look laparoscopy was undertaken to observe the adhesion preventive effect of the gel.
Results: Of the 45 patients 39 completed two laparoscopic surgeries. The overall results revealed that 79% of patients who received Adhibit had statistically significantly less adhesions than patients who did not receive Adhibit.
Conclusions: It is evident that adhesion prevention with the polyethylene glycol gel Adhibit was of major importance in these gynaecological operations. Adhibit proved to be a protective, well-tolerated agent, easy to apply and without any side effects. As, however, only about 80% of the patients showed no adhesions at the second-look laparoscopy, it should be better applied as a medicated product for complete adhesion prevention.

O 040

Optimal treatment with advanced micro-invasive surgery on the ovary

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Introduction: Especially in micro-invasive surgery on the ovary, meticulous and minimally traumatic surgery is indicated as this genital organ has to function at its optimal capability during a woman's reproductive life.
Material and Methods: The remaining ovarian hormonal reproductive capability was measured in 45 patients undergoing bilateral ovarian cystectomies for benign indications. Laparoscopic ovarian cyst enucleation with minimal coagulation and without the use of sutures was performed.
Results: The Clomifen stimulation test in these 45 patients revealed an equivalent ovarian function as prior to the surgery.
Conclusions: Minimal access surgery performed with the utmost care and knowledge revealed to be the prerequisite in advanced micro-invasive surgery for the treatment of female genital organs, especially the ovary. As far as the Clomifen stimulation test could reveal, no ovarian damage occurred in these patients. Advanced micro-invasive surgery enables us to perform more radical procedures with minimal organ destruction.

O 041

To evaluate the feasibilty and utility of conscious pain mapping in women with chronic pelvic pain

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Objectives: To evaluate the feasibility and utility of conscious pain mapping (CPM) in women with chronic pelvic pain. To correlate the site and severity of pain with lesions found on laparoscopy. To assess the degree of pain relief, in response to interventions following CPM.
Design: Prospective observational study.
Methods: Twenty-six women 20-45 years of age with chronic pelvic pain of alteast 6 months duration and no obvious gynecologic pathology were included in the study. Laparoscopic pain mapping under conscious sedation with fentanyl and midazolam was performed. Systematic evaluation of all structures in the pelvis using pressure and traction with a blunt probe as stimuli was done and patients asked to locate site of maximum tenderness. Interventions were performed based on the findings. Follow-up visits were arranged at 1 week, 1 month and 3 months. Pre- and postoperative visual analogue score (VAS) and pelvic pain score were compared.
Results: CPM was successful in 19 patients (73.1%), 7 patients required general anaesthesia. Uterosacral ligament tenderness was the most common finding (21.%). Endometriosis was detected in 15.7% and adhesions 15.8%. Operative procedures were done in 11 patients. On follow-up, 8 patients were pain free (VAS 0) and 9 patients had partial pain relief (decrease in VAS by 2 points).

Conclusions: Pain relief in successful CPM group was greater than in unsuccessful cases (78.9% vs 28 %). CPM reduced negative laparoscopy rate from 65% to 24% and averted one unnecessary operative procedure. Proper patient selection is critical for the success of CPM.

O 042

Endoscopic myomectomy followed by vaginal delivery: is it dangerous?

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The maternal age at delivery increasingly delayed, especially in those patients who needed assisted reproductive technique (ART) to concieve. Among them the reason for the failed treatment is the presence of fibroids (2-22%). Mostly the submucosal and intramural fibroids are in the background of the subfertility or miscarriage. The more or larger fibroids the poorer chance for conception. Removal of fibroids increases the conception rate and the chance to carry the pregnancy to term.
The main difference between a caesarean section (CS) and a myomectomy scar is that the previous is on the passive part of the uterus being under stretch only during the labour, the latter is on the active (myometrial) part of the uterus which is permanently under elongation, especially after the 20th week of gestation and when the pregnant is in the active phase of the labour. It means that not really the management of the labour, but the third trimester prenatal care needs to have an eye on. Another important difference to have to take into account is that the CS's scar involves the whole thickness of the uterine wall but the myomectomy scar just a part of it leaving untouched the part of the myometrial layer thus the uterine wall partly keeps its integrity.
Regarding to our studies it was not necessary to perform CS because of threatened uterine scar rupture on patients with previous endoscopic myomectomy. The reason for CS was always obstetrical (e.g. primipara breech presentation, intrauterine distress).

O 043

Remnant uterine septum in women of advanced reproductive age: obstetrical outcome

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Congenital uterine anomalies have been estimated to affect 0.06% to 10% of women. A septate uterus accounts for approximately 80% to 90% of these abnormalities.
After initial hysteroscopic metroplasty, a residual septum or adhesions are more frequent than normally anticipated.
It is reasonable to suppose that a septal endometrium is unsuitable for implantation of the blastocyst, independently of the extent of the uterine abnormality.
In a prospective observational study the reproductive efficiency in 94 patients with septate uteri who underwent uterine septum resection was analyzed. The reproductive outcome after initial resection and (if required) consecutive procedures were analyzed. The cumulative rate of viable pregnancy after initial and second hysteroscopy were calculated and the life table curves compared.
The patients were enrolled in the study: all together had two or more miscarriages. During the first hysteroscopy in 58 (62%) cases, the septum was completely removed. A residual septum was observed in 36 (38%) patients. After a minimal observation time of 24 months there were increases in the rates of pregnancies (from 60.0% to 79.3%) and subsequent deliveries (from 44.6% to 62.1%) after the strategy of severing the remnant, the differences being statistically significant. In fact following the achievement of a normal uterine cavity, the pregnancy rate was higher (62.1%). There was statistically significant of comparison the life table curves using log-rank test (0.04).
Women with a remnant uterine septum have an increased and reasonable chance of successful pregnancy after normalization of the uterine cavity.

O 044

Antibiotic prophylaxis in office operative hysteroscopy

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Introduction: we evaluate the risk of infectious complications in Office operative hysteroscopy.
Methods: 5450 women were treated, from 1995 to 2004, for benign intrauterine pathologies, using an office hysteroscopic procedure, in vaginoscopic approach without analgesia or anaesthesia. Distention of the uterus was obtained using an electronic suction/irrigation pump that can maintain a constant intrauterine pressure around 30 mm/Hg. Mechanical instruments (scissors and grasping forceps) with a calibre of 5 Fr. were used to treat cervical and endometrial polyps, as well as intrauterine adhesions and anatomical impediments. In 988 additional cases we used a Versapoint bipolar electrical generator to remove submucosal and partially intramural myomas, as well as endometrial polyps (ranging 0.5 and 4.5 cm). Antibiotic prophylaxis was not administered in all the cases. Each patient was assessed to evidence febrile status and the presence of infections
Results: febrile morbidity associated with pelvic pain occurred in only 6 patients (0.09%). No major infectious complications occurred. Four patients showed a positive pattern at ultrasound for idro/sacto-salpinx, not referred at the time of anamnesis. The remaining two presented severe endometriosis.
Conclusions: in our study, the incidence of post-operative infectious morbidity is substantially null and mostly relate to pathologies, usually considered as a contraindication to the procedure, not referred by the patients at the anamnesis. Furthermore, this very low incidence of infective complications could be relate to the maintaining of a constant intrauterine pressure around 30 mm/Hg. It avoids overdistention of the muscle fibers and hence patient discomfort, and prevent tubal spillage.

O 045

Laparoscopic surgery: a gold standard in adnexal torsion

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Introduction: Adnexal Torsion is the the twisting of an ovary, fallopian tube and/or paratubal cyst around its vascular axis. It induces a venous and lymphatic blockade complicated by massive congestion of the the ovarian or tubal parenchyma, hemorrhagic infarction, later followed by arterial blockade leading to gangrene and hemorrhagic necrosis which leads to rapid onset of acute pelvic pain.
Objective: To assess the epidemiology and risk factors of adnexal torsion, clinical findings and diagnostic methods, also to determine the best and most effective method of therapy.
Materials: Over 45 articles relating to diagnosis or therapy of adnexal Torsion in med line were reviewed and summarized. They consisted of retrospective studies and case reports.
Adnexal torsion is found mostly in young women but there are some case reports of its existing in menopausal women and pre-

menarchal girls. Almost always there are some coexisting cysts but it can also happen to previously normal Adnexa. Diagnostic were made mostly by vaginal sonography, CT.Scan or magnetic resonance.
Conclusion: The most effective way of diagnosis and therapy is due to all review studies the diagnostic laparoscopy which when performed without delay can preserve the adnexal and hormonal function by simple detorsion.

O 046

Ectopic pregnancy diagnosis and laparoscopic treatment: medicolegal implications

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Background: Ectopic pregnancy is still the major cause of maternal mortality in the first trimester. Its incidence is reported as 1 in 100 pregnancies, but is steadily rising and has doubled in the last 20 years.
Every year there are more than 20,000 emergency admissions for ectopic pregnancy.
Because of diverse and inconsistent presentation and absence of a single satisfactory diagnostic test, ectopic pregnancy remains a medico-legal minefield.
Discussion: The most litigious areas in relation to ectopic pregnancies are:
Failure to diagnose the disease: The high rate of missed diagnoses highlights the caveat that ectopic pregnancy should be suspected in all women of childbearing age presenting with symptoms related to pregnancy.
Delay in diagnosis and or treatment: In most case of litigation involving ectopic pregnancies the alleged breach of duty is in relation to delay in treatment.
Inadequate or inappropriate treatment: Laparoscopic treatment is the accepted standard of care and damages of up to £4000 has been awarded for an unnecessary laparotomy scar.
Conclusion: Ectopic pregnancy is the gynaecological condition with the greatest potential for acute morbidity and mortality. Atypical presentation of this disease and the rising incidence, offers pitfalls in diagnosis and treatment leading to increasing litigation in this area. The increasing number of successful litigations highlights the need for prompt treatment, meticulous follow up and patient counselling.

O 047

Experience of two Hellenic endoscopic centres in the use of icodextrin in gynaecological surgery: comparison with the ARIEL registry

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Aim: To record the early Hellenic experience of the use of Adept in routine gynaecological surgery as a formal Registry and to compare the results with those of ARIEL Registry.
Materials and Methods: Between February 2000 and December 2003, 118 patients (mean age±SD: 35.5±6) who underwent gynaecologic surgery either by laparoscopy (N=113) or laparotomy (N=5) in two Endoscopic Centres in Greece, were included in the Registry. ARIEL incorporated 6 European Countries, 150 Gynaecological Centres and included 2882 patients (2069 laparoscopies, 813 laparotomies). Surgeons provided feedback by anonymised coded data submissions and the Registry recorded a wide range of information on the routine use of Adept.
Results: The mean volume of irrigated and instilled Adept was 855 and 918 ml respectively. The total number of excellent and good scores, of a five scale scoring system for three categories scored in laparoscopic interventions, which included viewing, handling and overall satisfaction was 99%, 100% and 100% respectively, which was higher in comparison to other countries for Gynaecological surgery. The peritoneal fluid leakage at laparoscopy was considered in 71% as normal, in 18% less than normal and in 11% moderate. Abdominal distention and discomfort was in 12% and 18% respectively less than expected and in 60% and 70% as expected, while no adverse effect was recorded.
Conclusions: The findings of the Hellenic Registry, which are in accordance with those of ARIEL Registry confirm the acceptability and use od Adept as an adhesion barrier agent.

O 048

Laparoscopic hemi-hysterectomy in treatment of unicornuate uterus with rudimentary horn

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Unicornuate uterus accounts for approximately 13% of all Mullerian duct anomalies. According to American Fertility Society classification it has four variations, divided in IIa, with rudimentary horn communicating with the main uterine cavity, IIb with non-communicating rudimentary horn, IIc in which the rudimentary horn has no cavity and IId in which there is no rudimentary horn.
Unicornuate uterus with a non-communicating rudimentary horn and the presence of functional endometrium is accompanied by retention of menstrual blood, which distends its cavity and causes heamatometra with symptoms of dysmenorrhea and lower abdominal pain, which aggrevates during menstruation and worsens progressively in the adolescent after the menarche.
Although surgical treatment is not indicated in case of unicornuate uterus with a non-communicating rudimentary horn, it is of great importance the excision of the rudimentary horn with functional endometrium in order to prevent endometriosis and pregnancy complications, including ectopic pregnancy, miscarriage, e.t.c.
After the fisrt case report of laparoscopic management of unicornuate uterus with a rudimentary horn 20 cases, included two ours, have been reported in the literature. The removal of the horn and the ipsilateral tube may be performed by the use of bipolar coagulation, CO_2 laser or automatic stapling device.
Laparoscopic resection of communicating rudimentary horn by well trained gynaecologists, is associated by all the well known advantages of endoscopic surgery and should be the surgical method of choice.

O 049

Embryoscopy in cases of increased fetal nuchal translucency

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High resolution ultra-sonography is the most common established approach to the antenatal diagnosis of congenital abnormalities, during the first and second trimester. Nevertheless, in situations where there is a family high risk of recurrence of genetic disorders

that project onto embryonic phenotype or when antenatal ultrasound screening is highly suggestive of a congenital anomaly, embryoscopy could serve as a conclusive verification tool. We present our preliminary experience employing transcervical embryoscopy for direct visualization of the first trimester embryo in women that had opted for termination of pregnancy due to increased fetal nuchal translucency.
Embryoscopy has been applied in order to provide data on the phenotypic appearance of embryos of nuchal translucency between 4.1 and 4.7 mm. Embryoscopic examination of the embryo was performed before terminating the pregnancy by curettage. Embryonic phenotype and karyotype were determined and cross-linked. Embryoscopy was able to reveal a wide-ranging phenotype, from almost normal to grossly abnormal with significant structural defects on close examination. In some occasions, the abnormal phenotype has been attributed to a chromosomal abnormality, later confirmed by karyotype analysis. In these cases embryoscopic examination of the fetus, visualized characteristic external developmental abnormalities such us facial malformations, cystic hygroma, microcephaly and delayed limb growth.

O 050

Office operative hysteroscopy with the use of the N-Do system

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The progress of modern technology made it possible to develop minimally invasive techniques as office procedures, regardless of their diagnostic or interventional characteristics. Office operative Hysteroscopy is indicated for a series of uterine pathologies. In order to be performed, it requires anesthesia or extensive sedation. It is essential to evaluate the effect of local anesthesia during office operative Hysteroscopy, because it would facilitate and accelerate the Day Surgery procedure. The N-Do system is a helpful tool towards this direction. It is composed by a probe, to be inserted into the uterus, and a rigid 5Fr catheter, which is introduced inside the probe's working channel. The catheter contains a needle at its distal end which can gradually curve as it exits. This geometry allows the endoscopist to inject various drugs in various sites of the uterus, at different depth of tissue, according to the need of each pathology. The sliding function of the handle controls exit, retraction and curve of the needle to the desired level. The result of the N-Do system application is that operative Hysteroscopy can be performed with safety, accuracy and patient's optimal tolerance, in various circumstances, like endometrial polyps, adhesions, uterine septums, hysterosuction in voluntary interruption of pregnancy, insertion and removal of IUD, undermucosal myomas.

O 051

Enucleation in toto, a new technique of hysteroscopic myomectomy

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Objective. To describe the safety and effectiveness of a new technique for hysteroscopic resection of uterine submucous myomas.
Measurements and Main Results: with a hystero-resectoscope and Collins electrode, an elliptic incision of the endometrial mucosa that covers the myoma is made at the level of its reflection on the uterine wall until the cleavage zone of the myoma is reached.
Connective bridges between myoma and surrounding muscle fibers are resected. This allows nearly complete protrusion of the myoma into uterine cavity, enabling the surgeon to complete myomectomy by slicing the lesion, and reducing risks of perforation and thermal damage. The procedure was performed in 389 women with 397 myomas. 81(21%) were G2 myomas, 199 (51%) were G1 myomas ad 109 (28%) were G0.
Considering G2 myomas, 17 (20.7%) myomas were < 2 cm in diameter, in 61(75.9 %) myomas were between 2 and 4 cm in diameter, and in 3 (3%) exceeded 4 cm. Mean operating time was 31 minutes (range 16-44 minutes), with no complications.
Conclusion: Hysteroscopic enucleation in toto was effective with excellent results and advantages, and could be used by expert hysteroscopists for resection of G2 myomas.

O 052

Ruptured interstitial heterotopic pregnancies: techniques and outcome

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From 1992 to 2005, eight heterotopic pregnancies were managed laparoscopically. Of those, three were corneal-interstitial. All three had conceived by IVF treatment. Between five and six weeks of gestation they presented with internal haemorrhage and during surgery, all ectopics were found to have ruptured. In one case the intrauterine pregnancy was triplet, another twin and the other was a singleton. In all cases, severe intra-abdominal haemorrhage was found during surgery. Bi-polar electrocautery was found not to be effective in controlling the bleeding so the uterine wound was cleaned of trophoblastic remnants and subsequently sutured. In all three cases the pregnancies continued after surgery. The triplet pregnancy was reduced to twins and all three continued to term. All women were delivered by caesarean section between 37 and 39 weeks of gestation and the uterine wound was assessed. The sites were clear of adhesions and there was no sign of uterine-wall rupture or dehiscence. We feel that laparoscopic surgery is an appropriate method for managing ruptured heterotopic pregnancies as long as correct suturing techniques can be implemented.

O 053

Effect of chronic pelvic pain on the endocrine system: an example of chronic stress

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Background: Chronic pelvic pain in women is a common disorder, affecting as many as 15% of adult women, and often provides both a diagnostic and therapeutic challenge. The etiology of chronic pelvic pain is multifactorial. The objective of this prospective case-control study was to determine the effect of chronic pelvic pain on the endocrine system.
Subjects and Methods: Thirty-nine women with chronic pelvic pain, aged between 18 and 45 years, who underwent diagnostic laparoscopy, were enrolled in the study (study group). Thirty aged-matched women with no abnormal findings served as controls. Both groups underwent evaluation of adrenal, ovarian and thyroid function.

Results: Among women with chronic pelvic pain, 51% (20/39) had endometriosis, 15% (6/39) had cystic ovarian masses, 10% (4/39) had pelvic inflammatory disease, 8% (3/39) had pelvic adhesions and 3% (1/39) had pelvic congestive syndrome. In 13% (5/39) of the cases no etiology was found. Women with chronic pelvic pain had significantly increased cortisol levels compared to control women [mean values 17.70 μg (range 12.8-20.2 μg) vs 9.15 μg (range 8.6-10.0 μg) P<0.0001). Statistically significant differences were also observed in T3, TSH and IGFBP-1 levels.
Conclusions: Chronic pelvic pain exerts significant alterations in the endocrine system homeostasis, aiming at endocrine system adaptation to chronic stress.

O 054

Laparoscopic management of missed ovarian malignancies: does it affect prognosis?

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Aim of the study: To evaluate whether initial laparoscopic management of ovarian malignancies that were missed during the preoperative diagnostic work-up compromises further management and prognosis.
Patients and methods: We analyzed 14 cases with a variety of ovarian malignancies that were initially treated laparoscopically, during the last 3 years. Of these, 7 cases were managed laparoscopically in our Institution (group 1), and 7 in other, mostly private hospitals (group 2). All cases underwent a complete open staging procedure in our gynecological oncology unit.
Results: Mean patient age was 23 years (range 17-38). Preoperative suspicion for malignancy existed in 4/7 cases in group 1, and in 1/7 cases in group 2. Mean interval times for the staging procedure differed significantly between the two groups (8 days vs 23 days, p<0.0001). At initial laparoscopic evaluation, the tumor appeared to be confined to the ovary in 12/14 cases. Cystectomy was performed in 9 and ovariectomy in 5 cases, respectively. Tumor rupture and spillage occurred in 5/7 cases of group 1 and 6/7 of group 2. Frozen section was suggestive of malignancy in 11/14 cases. Final histology was suggestive of an epithelial borderline tumor in 10 cases, an invasive epithelial ovarian cancer in 2 cases, an immature teratoma in 1 case, and a grannulosa cell tumor in 1 case. After the staging procedure 2 cases in group 2 were found with tumor deposits beyond the true pelvis, that were not reported at laparoscopy. Chemotherapy was administered to 3 patients with invasive cancer and tumor rupture during the laparoscopic procedure.
Conclusions: Laparoscopic management of a missed ovarian malignancy can occur despite an extensive preoperative work up. Cystectomy is more frequently complicated by rupture than adnexectomy. A complete staging procedure is mandatory in all cases, as soon as final histology is available. Delay in performing appropriate surgery may cause upstaging of the disease.

O 055

Laparoscopic retroperitoneal anatomy in gynaecological surgery

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Objective: to demonstrate the role of laparoscopy in the study and the teaching of pelvic retroperitoneal anatomy. Setting: large tertiary care hospital with university affiliation. Design: in vivo laparoscopic views of the retroperitoneum. Methods: Between January 2000 and December 2003, operative pictures were taken at different steps of the retroperitoneal dissection in cases of gynaecological cancer or prolapse managed by laparoscopy.
Results: Approaches and anatomical limits of paravesical, pararectal, ilio-lumbar, rectovaginal, retropubic spaces were laparoscopically described in this study. Laparoscopic dissection in those spaces conducted to a precise identification of connective tissues, muscles, vessels and nerves of the pelvic retroperitoneum. The different functional structure identified in laparoscopic views were: collateral branches of internal iliac vessels, muscles of pelvic side wall, parametrium, paracervix, vesico-uterin ligament, lateral vesical ligament, obturator nerve, lumbosacral nerve, splanchnic nerves and all parts of pelvic ureter.
Conclusion: Laparoscopy appears to be a new and attractive tool of teaching in pelvic retroperitoneal anatomy. Furthermore the knowledge of this anatomy is essential in advanced gynaecological laparoscopic surgery to a better preservation of functional structures and to an appropriate management of surgical complications.

O 056

Laparoscopic management of endometrial cancer in obese patients

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To assess the feasibility and utility of laparoscopic treatment of endometrial cancer in obese patients in Large university hospital with tertiary care facilities
Retrospective study (1990-2001): 42 obese patients (BMI>30) with clinical stage I endometrial carcinoma managed by laparoscopy among 161 patients. The laparoscopic surgery included peritoneal washings, hysterectomy with bilateral annexectomy, pelvic lymphadenectomy depending on the results of frozen section.
41 patients were managed completely via laparoscopy. One conversion to laparotomy was required due to ovarian spread. The mean operative time was respectively 159 min anf hospital stay 5 days. The mean number of lymph nodes removed was 10. In six cases pelvic lymphadenectomy was not performed due to limitations of access and/or poor tolerance secondary to obesity. Postoperative complications included: one re-operation after 2 days due to haemorrhage and two cases of obturator nerve neuralgia. The disease was upstaged in 12.1% of cases. After a median period of follow-up of 72 months, disease had recurred in 3 women (7.3%). No port-site recurrences were found.
Conclusions: Despite some limitations, our results indicate that laparoscopic management of endometrial carcinoma is feasible in obese patients. Laparoscopic treatment was as radical as the laparotomy approach and superior to the vaginal approach. It allows complete staging with clear inspection of the entire peritoneal cavity, and the option of lymphadenectomy in a single surgical procedure. Furthermore, our results show minimal morbidity and similar survival rates to the traditional approach. Consequently, the laparoscopic route is particularly useful for patients who suffer from obesity.

O 057

Long-term results of myomectomy in laparoscopy and laparotomy

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The aim of this study was to compare a long-term results of laparoscopic and open myomectomy. This was a retrospective study of 165 women who underwent myomectomy in Clinic Obstetrics and Gynecology, Jagiellonian University Hospital, between January 1992 and December 2000. In the follow-up studies, regression of symptoms and the number of pregnancies were similar in both groups, but in the laparoscopic group there were smaller recurrence rate of myomas than in open group.

O 058

Surgical treatment of deep infiltrating endometriosis in patients with pain and infertility

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Objective. To evaluate the efficacy of surgical treatment of histologically proven deep infiltrating endometriosis (DIE) in women with pain and infertility in terms of pregnancy rate and pain relief.
Study design. Retrospective study. Tertiary care university department.
Patients and methods. Between October 2001 and December 2004, 54 infertile women with symptomatic DIE were treated by radical laparoscopic excision of DIE. Postoperative pregnancy rates and pain relief were evaluated on the basis of the women's replies to the questionnaire sent to them. Surgical procedure consisted of the laparoscopic excision of all visible and palpable lesions, including sacrouterine ligament resection, excision of rectovaginal nodules, ureterolysis and laparoscopically assisted bowel resection.
Results. Of the 54 women, 45 (83%) responded, 36 of the 45 (80%) had attempted to conceive. Despite a short follow-up period, the postoperative pregnancy rate was 72.2% (26/36); 17 (65.2%) women conceived spontaneously and 9 (34.8%) through IVF. Twenty-five (69.4%) women had had 1-3 surgeries before admission to our centre, and 5 (13.5%) 1-3 unsuccessful IVF attempts. Women who became pregnant spontaneously had significantly less previous surgeries than those who became pregnant through IVF. Pain relief was reported by 74% of the respondents.
Conclusion. Surgical treatment of DIE is a demanding procedure but when properly performed results in high pregnancy rates and pain relief. The most important is the quality of the first surgical procedure. Repeated surgeries significantly decrease the chance of pregnancy.

O 059

Modified transobturator tape in the management of genuine urinary stress incontinence: the Alexandria technique

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Objective: To assess the efficacy of modified transobturator tape in the management of genuine stress urinary incontinence.
Design: Prospective study.
Setting: Alexandria University, Department of Gynecology and Obstetrics
Patients: Twenty cases of genuine stress urinary incontinence attending the outpatient clinic at El-Shatby University hospital. All patients were subjected to full history taking, clinical examination, cough stress test and preoperative cystometry.
Intervention: Modified Transobturator Tape was done for all patients
Technique: The original tape was replaced with 3 partS tape. The central piece is a vaginal graft 3cm x 0.8cm attached on both sides to a 10cmx0.8cm monofilament polyprolene tape that transfixes the obturator foramina by the aid of special curved needle and appears on the skin of the medial side of the upper thigh at the level of clitoris. The vaginal graft part of the new tape is placed under the mid-urethra after making a transverse incision opposite the mid-urethra to get the vaginal graft and open the para-urethral spaces for the prolene tape to pass through.
Main outcome measure: Follow up one and eight weeks postoperative by cough stress test and cystometry.
Results: Prelimenary results are 80% success rate.
Conclusions: Modified transobturator tape is very effective in the management of genuine stress urinary incontinence and more economic than the original tape. Natural tissue supporting the urethral angle. Easy surgical technique.

O 060

Fetal surgery: aspects of open and minimally invasive surgery

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Fetal surgery has developed in the last decade immensily. Areas of fetal surgery are mainly rstricted to fetal abnormalities that induce severe problems post partum that might be solved by intrauterine fetal surgery prior to delivery. Open surgery which was performed first has mainly failed due to complications caused by opening of the uterus and the membranes. Premature rupture of the membranes is the main reason for failure of open surgery leading to premature delivery and in many cases to fetal death. Today minimally invasive surgery is the procedure to be favored. Due to the minimally invasive access e.g. by ultrasound guidance or via fetoscopy the main problem of premature rupture of the membranes and premature delivery are reduced. Today fetal surgery by ultrasound guidance, e.g. intrauterin transfusion via chordocentesis or drainage of hydrothoraces are a well known an established method. Fetoscopical guided operations have it's place e.g. in the field of diaphragmatic hernia as an example. In the future this field of indications will spread e.g to closure of spina bifida or intrauterine operations of carcial abnormalities e.g. hypoplastic left ventricle.

O 061

A new technology of 3-dimensional laparoscopic imaging system (VS-1) - a prospective randomized controlled trial

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The VS-1 technology is a new 3-dimensional (3D) imaging system used for laparoscopic surgery. It is based on a microscopic array of hundreds of thousands of lenses that form a single apparatus, providing streaming 3D imaging without the side-effects of previous 3D systems. The present study analyzes the above system in terms of learning curve and operative results as compared to standard 2-dimensional (2D) imaging.
The trial is prospective. Ninety eight patients, randomly assigned for the VS-1 3D or 2D Laparoscopic imaging systems, 49 patients in each group. Laparoscopic surgery of different skill levels performed by novice, experienced or highly experienced surgeons.
Preliminary results comparing the VS-1 system to the existing 2D technology showed a reduced procedure time (27.8 minutes vs.

36.9 minutes respectively) and estimated blood loss (15cc vs. 42cc) for procedures of short duration.
Overall, for all types of procedures, novice and experienced surgeons showed an 8% and a 14% decrease, respectively, in operative duration.
Performers reported having a better depth perception, anatomic understanding and procedure efficiency as well as more confidence and efficiency during complicated maneuvers. No user side effects were reported.
Conclusions: Our preliminary findings show that the VS-1 3D imaging system provides improved operative results with greater surgeon confidence and satisfaction and without user side effects. Further studies are required.
We believe that the VS-1 system will improve learning curves of novice surgeons and will offer experienced surgeons a better tool for complex surgical procedures.

O 062

Transcervical resection of endometrium in the treatment of menorrhagia: does age influence the outcome?

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Objectives To evaluate the menstrual outcomes following TCRE and to identify whether age of the patient influences the outcome.
Methodology A cohort study of the 80 cases undergoing TCRE for menorrhagia, between January 2001 and December 2002, was carried out. Data was collected retrospectively from the case notes. Patients were divided into two broad groups – A and B – based on the age. Group A comprised of patients aged ≥45 years and group B consisted of patients aged ≤45 years. There were 46 patients aged ≤45 years (Group B) and 34 patients were aged ≥45years (Group A).
Outcome Measures Amenorrhoea, improvement in menstrual symptoms 6 months following TCRE, repeat medical/surgical intervention for recurrence of menstrual symptoms, within 2 years following TCRE.
Results Amenorrhoea was reported by 53%, improvement of menstrual symptoms by 38% and no improvement was reported by 9% of the patients in group A. In group B, amenorrhoea was reported by 24%, improvement of menstrual symptoms by 37% and no improvement by 39% of patients. Repeat medical/surgical intervention was noted in 31% of patients in group B as compared to only 6% of patients in group A. Overall success rate was higher (91%) in patients aged ≥45 years as compared to 61% in patients aged ≤45 years.
Conclusion This study suggests that patients aged ≥45 years are 50% more likely (Likelihood ratio 1.5) to have a successful outcome following TCRE for menorrhagia compared to patients aged less than 45 years.

O 063

Laparoscopic autologous orthotopic and heterotopic ovarian transplantation in rabbits

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Aim: To assess the feasibility, viability and ovarian function after laparoscopic ovarian transplantation without anastomosis in rabbits.
Materials and methods: 43 virgin adult whiteNew Zeland/ California female rabbits weighting 3350-4550 gr and aged 3.5-4.5 months were used. The animals were randomized into three groups: Group A (control group, 10 rabbits) undergoing ovariectomy, Group B (17 rabbits), ovariectomy and intraperitoneal autologous heterotopic transplantation and Group C (16 rabbits), ovariectomy and autologous orthotopic transplantation. The animals were anaesthetized by s.c. injection of xylazine (10 mg/kg) and ketamine (40 mg/kg). Once the ovaries were exposed,they were removed and all the ovarian tissue was transplanted either in a pocket created in the lateral abdominal wall, or at the same side without anastomosis. A second look laparoscopy was performed 30 days postoperatively and biopsies were taken from the ovaries for histologic evaluation.
Results: In Group B and C plasma E2 on days 7 and 30 (170±42, 132 ±51 and 326±39, 254±28 respectively) were similar but significantly higher than in Group A (254±36, 141±34) (p≤0.05). In Group B on day 7 after surgery onwards and in Group C until day 30, FSH remained low, comparable to Group A (78
±12, 69±18, 31±9.2, 26±7 and 118±35, 222±39 IU/L, respectively). There were no statistical differences between heterotopic (Group B) and orthotopic (Group C) implants in FSH concentration.
Conclusions: The operative technique with laparoscopy is feasible for ovarian transplantation, the animals' tolerance excellent and the implants were functionally successful.

O 064

The risk of ureteral obstruction in vaginal uterosacral suspension

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Objective: Uterosacral-paracervical ligament complex supports the cervix and upper quarter of the vagina and vaginal apex. Failure of this mechanism causes uterovaginal prolapse. Resuturing of the uterosacral ligament to the vaginal vault is therefore undertaken at the time of vaginal hysterectomy as a treatment and preventative for uterovaginal prolapse. Uterosacral suspension is associated with a 0.65% to 10.9% ureteral obstruction rate. This study was undertaken to examine the rate of ureteral obstruction with vaginal uterosacral suspension.
Design: Retrospective observational study.
Setting: Weston General Hospital NHS Trust, Weston-super-Mare, UK.
Patients: 123 consecutive patients underwent vaginal hysterectomy with uterosacral suspension between the years 1999 to 2005.
Results: One patient (0.8%) had ureteral obstruction attributed to uterosacral suspension. (The case will be discussed at presentation)

Conclusion: Proximity of ureter to uterosacral ligament makes it vunerable during uterosacral suspension. Awareness of anatomical relation, operator experience with proper instrumentation decrease the ureteral injury rate.

O 065

Laparoscopic diagnosis and management of adnexal masses

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OBJECTIVE: Ovarian tumors represent a common clinical problem. The aim of this study was to evaluate the laparoscopic approach as a method of diagnosis and treatment of adnexal masses.
MATERIALS AND METHODS: 118 patients with ultrasonographic demonstration of 125 cystic adnexal masses met the entry criteria of the study. Menopausal women with adnexal masses that had sonographic pattern suggestive of malignancy were not included. The mean age of the patients was 31,04 years (range: 16-59), the mean diameter of the ovarian cyst was 5,29 cm (range: 2,9-13,5), and the mean CA125 was 18,8 U/ml (range:0,7-189,39).
RESULTS: Histological diagnosis was endometriosis in 47 of the excised cysts, simple cysts in 32, para ovarian cysts in 4, serous cystadenomas in 9, mucinous cystadenomas in 6, luteal cysts in 4, cystic fibroma in 1, dermoid cysts in 20 and serous borderline tumors in 2. All patients underwent diagnostic laparoscopy followed by endoscopic management. The procedure was converted to laparotomy in one case of borderline tumor and in one case of bilateral endometriomas with extensive adhesions. Ovariectomy was performed in 8 patients including three menopausal women. In the rest cases cystectomy was the method of treatment.
CONCLUSION: Laparoscopic diagnosis is safe and accurate and endoscopic management of benign adnexal masses is safe and with low morbidity. Careful surgical diagnosis and respect to the principles of oncologic surgery, may allow laparoscopic management of borderline tumors.

O 066

Diagnostic management in case of postmenopausal bleeding: an assessment of patients' preferences

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Objective: To assess patient's preferences for diagnostic management in case of postmenopausal bleeding.
Design and Methods: A structured interview was designed for systematic assessment of patients' preferences in the diagnostic work-up of postmenopausal bleeding. Patients were given information about the chance of endometrial carcinoma or benign disease. They were informed about different diagnostic strategies: expectant management after ultrasound or complete diagnostic work-up including invasive procedures. This study was performed in the St. Antonius Hospital, a large teaching hospital with office hysteroscopy facilities. A structured interview was taken from 40 patients. All these patients had had an office hysteroscopy in the diagnostic work-up for postmenopausal bleeding at which no malignancy had been found. All patients had completed the diagnostic work-up.
Results: Most women wanted to be 100% certain that carcinoma could be ruled out, a few patients were willing to accept more than 1% risk of missing cancer. Women were more likely to accept an expectant management in case of benign disease (endometrial polyp). However, if the risk of recurrent bleeding exceeded 25% the majority of women would prefer immediate diagnosis and treatment.
Conclusion: Women are not prepared to accept a particular risk on cancer and want cancer to be ruled out with 100% certainty even if this includes an invasive diagnostic procedure. This finding implicates that the measurement of endometrial thickness with transvaginal ultrasound as a first line test in the assessment of postmenopausal bleeding should be reconsidered.

O 067

Are small uterine anomalies really unimportant

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Study objective: To evaluate whether small uterine anomalies or arcuate uteri really represent an unimportant anatomic anomaly. Study design: The study involved 933 women after hysteroscopic transections of a uterine septum: 483 women with a large septum (1.5 cm to total) and 450 women with a small septum (1-1.5 cm). Reproductive data regarding natural conception and assisted reproduction comparing women with large and small septa were evaluated and compared. Results. The structure of 957 pregnancies before the operation significantly differed to the structure of 564 pregnancies after the operation (P<0.000). Similarly to women with large septum in women with arcuate uterus the spontaneous abortion rates decreased from 83% to 19% (P<0.000000) and the preterm birth rates decreased from 40% to 11% (P<0.00000). Improved pregnancy outcomes after surgery were found both in large and in small uterine septum groups. Embryo transfers (ETs) in 823 IVF/ICSI cycles before and after hysteroscopic metroplasty in larger (AFS grade 5) and in smaller (AFS grade 6) uterine septa were also analysed and compared. Similarly to women with large septum the pregnancy /ET rate after surgery in women with arcuate uteri increased from 14% to 29% and the abortion rate decreased from 69% to 19%. Conclusions. Uterus with small septum (AFS 6) or arcuate uterus is not an unimportant uterine anomaly. Contrary to classical observations arcuate uterus has been evidenced as an important hysteroscopically preventable reproductive health risk variable. The revision of existing classification of uterine anomalies would therefore be mandatory.

O 068

Urgent laparoscopy in gynecological emergencies

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The aim of this study is to prove the usefulness of urgent laparoscopy instead of standard research operational procedures in acute abdominal pain in gynecological emergency conditions. The material is consisted by 12 women asking for emergency services in our hospital from Jule 1999 until October 2004. The ages of the women were between 14 and 45 years old and all were complaining for acute low abdominal pain. The routine diagnostic setting after the more general surgical pain origin exclusion focused the

diagnostic interest on pelvis and specially on adnexa. Then the further management of these women performed by laparoscopy. This was decised to be diagnostic at a first glance, but later to get individualized up to findings. In 3 women corpus lateum cysts were found to be ruptured and careful washing up and drainaging was followed. 2 appendicectomies were executed after inflammation was proved, but in one case of them a salpingectomy was become along due to salpingitis. One ovary rupture was managed. A case did not receive surgical diagnosis indicating an internalistic reason for the pain. The remaining 5 cases concerned adnexa cysts. In 3 women the cysts was found ruptured. In one woman the cyst was found torsioned and at the last one, the operation was converted to laparotomy. In a lot of cases the few or much more adhesions found were obliged to be solved along. The mean day nursing was 2.36 days.

O 069

Laparoscopic staging in ovarian cancer

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Introduction: laparotomy is the operative approach of choice for ovarian cancer. However, despite the introduction of structured pre-operative assessment e.g. by means of a Risk of Malignancy Index the common use of laparoscopy to treat adnexal masses still results in a significant number of unsuspected cases of cancer. Such cases of unsuspected ovarian or tubal cancer diagnosed only after primary surgery will benefit from laparoscopic staging because this a) avoids a second laparotomy, b) often avoids a median incision on top of a recent transverse incision, and c) avoids delay in starting adjuvant chemotherapy.
Technique of laparoscopic staging: to some small series in the literature we may add our own series of 14 patients with a malignant (11 ovarian cancer, 1 tubal cancer) or borderline (2) tumour diagnosed after primary laparoscopic or laparotomic treatment for an adnexal mass. Patients with histologically proven adnexal cancer and no signs of metastasis or residual tumour are eligible for laparoscopic staging. The laparoscopic procedure includes adnexectomy of residual adnexae, supracolic omentectomy, para-aortal lymph node dissection and pelvic node sampling, and random biopsies. We started performing the omentectomy using a laparoscopic automatic gastro-intestinal stapler, but we now routinely use bipolar vessel sealing, which results in easier haemostasis. Pelvic lymph node dissection (in 6 out of 13 evaluable cases) used not to be done routinely but is currently standard practice.
Results: In one obese patient the operation was converted to laparotomy because of inaccessibility of the para-aortic region. In the remaining patients, mean operating time was 3 hours 16 min (range 2:30 – 4:40). Para-aortic lymph node dissection resulted in a mean number of 5.5 (range 1-10) nodes. Two of the malignant ovarian tumours were upstaged from stage Ic to IIIc on basis of para-aortal lymph node involvement with or without omental metastasis greater than 2 cm in diameter. No major complications occurred. Patients could be discharged after a mean of 2.5 (range 2-4) days. Chemotherapy was started in 7 patients within 8 days after laparoscopic staging.
Conclusion: laparoscopic staging is a safe and adequate procedure that avoids morbidity and allows timely initiation of subsequent chemotherapy if required. There is no reason why laparoscopic staging should not replace staging through a symphysio-xiphoid incision in patients who have recently undergone inadequate surgery for an unsuspected carcinoma of the ovary.

O 070

Endoscopic force feed back instruments; the future becomes reality?

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Since centuries we try to manipulate our environment by devices which increase or decrease forces exerted by our hands or which reduce the distance between operator and the object. This “unilateral” telemanipulation is used in our conventional laparoscopic instruments. Bilateral telemanipulation gives feed back about the forces applied on the instrument tip. One of the drawbacks of laparoscopy is the low accuracy of positioning combined with the lack of force feed back at the tip of the instrument. The operator does not have any information about the resistance of the handled tissue except by the “one to one” movement; the straight forward force along the axis of the shaft when the operator pushes against a piece of bone.
Tele-manipulation systems have partially been implemented in robotic systems but they are very complicated, expensive and ask for other operative techniques. Simple conventional-like instruments supplied with force feed back have to settle with high requirements; the need to be sterilized, working conditions in fluid environments, the combination with electro surgery, a light weight and ergonomic shape, and low costs. The integration of optical fibres to transport information of the forces in the tip has been used to develop a new concept for new laparoscopic instruments. The background of this new concept will be explained. By this instrument more complicated procedures with lower risks of complications can be performed. The learning curve could be shortened. Moreover the characteristic tissue impedance during a procedure can be used to feed virtual reality training computers.

O 071

Fibroid embolisation – Long term follow up data >5 years. Pregnancy data and combined procedures

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Pregnancy Data
Objective: The study follows 62 pregnancies in 49 women following Uterine Artery Embolisation. This being the largest reported series world wide of pregnancy post Uterine Artery Embolisation.
Results: 32 Live Births, 5 ongoing pregnancies, 4 terminations, 18 miscarriages, 1 Ectopic pregnancy,
Updated demographics and more detailed complication data will be presented.
Conclusion: When demographics of patient population in question considered there does not appear to be an excessive obstetric risk following Fibroid Embolisation.
Follow up data
Objective: To evaluate long-term (>5 years) results of fibroid embolisation in women who underwent Uterine Artery Embolisation for fibroids.
Results: Patient satisfaction following UAE 5-7 year post treatment. A total of 86.6% of women would recommend the procedure to others, 87.8% would still choose embolisation, 60.5% were very satisfied with the procedure and 84.9% of women reported an improved quality of life. We had an infection rate of 0.6%, hysterectomy was performed post embolisation in 6.4% and a recurrence rate of 3.5% was reported. 7.6% of women had permanent amenorrhea following embolisation but only 1 patient under the age of 45. 2.3% had hysteroscopy for persistent vaginal discharge. More detailed data will be presented.
Conclusion: Our data would suggest that Uterine Fibroid Embolisation is an effective long-term treatment for indicated patients with fibroids.

Combined Procedures
UFE + myomectomy (open/laparoscopic/hysteroscopic) + TCRE for adenomyosis.

O 072

Uterine cervix pathology in laparoscopic supracervical hysterectomy

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1730 surgeries were done since 1991.
Objective: To determine whether pre-operative treatment of premalignant cervical lesions could be associated with postoperative cancer.
Design and methods: A retrospective analysis of case notes of 620 women who had laparoscopical supracervical hysterectomy for adenomyosis and myomas and prior laser treatment of the cervix (ectopy, leucoplakia, CIN I-III) in the clinic between 1991 and 2004. Postoperative viewing included colposcopy, brash-cytology, laser fluorescental spectroscopy.
Results: Cervical cancer and CIN II-III determined in no cases. Cin I was diagnosed in 5 (0,8%) patients, dyskeratosis in 7 (1,1%), and ectopy in 9 (1,5%) women.
Conclusion: Pre-operative treatment of cervical lesions allows remain cervix and prevent pelvic prolaps, urinary disorderes and sexual dysfunction.

P 001

Evaluation of office hysteroscopy in diagnosis and treatment of complex endometrial hyperplasia with or without atypia

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Study Objective: Evaluation of Office Hysteroscopy in follow up of women with complex endometrial hyperplasia
Methods: We examined 51 women.In 35 women between 35-45 years old , 32 had complex hyperplasia without atypia, and 3 nulliparous women had complex hyperplasia with atypia. 16 women were between 45-65 years old and they had complex hyperplasia without atypia. All women after diagnosis were in treatment with progesterone i.v or p os. 3 months after diagnosis they all had follow up with vaginal ultrasound, office hystreroscopy and biopsy. Forceps and scissors were used. No patient had either local or general anesthesia.
Results: 33 women without atypia had better results in 3 months follow up, and they continued the same dosage of progesterone. Follow up was repeated every 6 months. 15 women without atypia and 3 women with atypia had the same results in 3 months follow up. We increased the dose of progesterone and they had a follow up in 3 months again.All women had better results , they continued the same dosage of progesterone and they had a follow up in 6 months again. 3 cases in age over 42 years old, without atypia but with persistent clinical symptomatology, resection was performed. 1 woman with atypia had a successful pregnancy in 3 years follow up.
Conclusion: Office Hysteroscopy is a simple and safe method which can be done without anesthesia for the follow up of patients with complex endometrial hyperplasia .This method allows the individualisation of dosage and treatmentaccording to findings.

P 002

Office operative hysteroscopy: a comperative study

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Study Objective: Comperative study in evaluation with Versapoint and Operative Instruments in Office Operative Hysteroscopy.
Method: We examined 251 women. Of all cases 16 had endocervical adhesions, 21 endometrial adhesions, 42 both endocervical and endometrial adhesions. 73 women had polyps, 22 myomas till 2 cm, 11 had diaphragms and in 66 cases only biopsies were taken. We used Continuous flow Bettocchi Operative Hysteroscope size 5,forceps-scissors and Versapoint. No patient had either local or general anesthesia.
Results: In 12 cases with endocervical adhesions we used only scissors, but in 4 cases we used scissors and Versapoint. In 10 cases with endometrial adhesions, we used scissors and in 11 Versapoint. In 42 women with both endocervical and endometrial adhesions, in 26 we used scissors and in 16 scissors and Versapoint. In 48 cases with polyps less than 1 cm,we used forceps, scissors or both, and in 25 cases with polyps between 1-2 cm we used only Versapoint. In 5 cases with myomas less than 1 cm, we used only forceps and scissors and in 17 myomas greater than 1 cm we used Versapoint. In 2 cases with small diaphragms we used only scissors and in 9 cases with big diaphragms we used Versapoint. In all cases with polyps-myomas biopsies were taken with forceps from the base of the lesion. Biopsies were taken from all 251 cases.
Conclusions: In diagnostic and operative office hysteroscopy we used Versapoint and Operative instruments or combination according to pathology with very good results.

P 003

Surgical Management of large ovarian cysts in premenopausal women

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OBJECTIVE: to evaluate the best surgical approach to ovarian cycts of minimum 15 cm in diameter in premenopausal women with benign presurgical characteristics.
METHODS: Between October 2001 and May 2005 fourteen patients (age 28±) with an ovarian cyst of 15 cm or more and presurgical evaluation excluding malignancy were randomly allocated to laparoscopic or laparotomic approach. Duration of surgery, pain on day 1 after surgery, early and late complications, hospital stay, return to normal activity and work were evaluated.
RESULTS: A cystectomy was successfully performed by laparoscopy in 5 patients and by laparotomy in 2 patients; unilateral oophorectomy was performed by laparoscopy in 2 patients and by laparotomy in 5 patients. Operating room times were longer for the laparoscopic group, median 150 minutes, versus median 120 minutes for the open group. Mean cysts diameter was 24±12,6 cm in the laparoscopic group and 21,8±6,5 in the laparotomic group. Perceived postoperative pain on postoperative day 1 was significantly lower in the laparoscopic group. Duration in the hospital was longer in the open group, median 5 days, versus median 3 days for laparoscopy. Return to normal activity and work after 15 days were observed in all the patients treated by laparoscopy and in only 3 patients treated with open surgery.
CONCLUSIONS: Laparoscopic treatment of large ovarian cysts gives the same results as the laparotomic. Laparoscopy treated patients have less postoperative pain, shorter hospital stay, rapid return to normal activities and work.

P 004

Laparotomic myomectomy compared to laparoscopic myomectomy: a retrospective study

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OBJECTIVE:The purpose of this study is to evaluate the advantages and the disadvantages of the laparoscopic myomectomy, compared to the laparotomic myomectomy.
MATERIAL AND METHODS: This retrospective study is comparative, which is done for the first time in Lebanon. It was performed on 173 non menopausal women, of which 97 underwent a laparotomic myomectomy and 76 underwent a laparoscopic myomectomy.The considered parameters in the comparison of these two techniques are the age, the number,the size and the location of the fibroids,operative time,blood loss, fever,resolution of ileus,and pain, assessed by the type and the quantity of analgesia used, the length of the hospitalization. The statistical tests used in this study are Person's X2 test, ANOVA and the epsilon test.
RESULTS: For a comparable number of fibroids, the ones removed by laparoscopy are smaller, compared to laparotomy. The operative time and the efficacy were without statistical difference. The fall of hemoglobin was higher by laparoscopy although the need for blood transfusion was null against 11,34% for laparotomy. We reported neither cases of fever nor cases of infection against 49,5% and 8,2% respectively for laparotomy, nor cases of postoperative bleeding against 1%, nor cases of case of thromboembolism against 1%. The postoperative pain disappeared in two days instead of four, the hospital stay was limited to two days instead of four and the pain was minimized for laparoscopy.
CONCLUSION: For well selected patients, the laparoscopy myomectomy is very tempting, compared to laparotomy.

P 005

A tension free procedure in vaginal vault prolapse

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Objective: we have recently developed the obturator route of tape passage for resolving vaginal vault prolapse.
M&M: 2 patients were operated with TOT by posterior approach to treat evident vault prolapse after hysterectomy.Preoperative study protocol included:medical history,gynecological examination,perineal ultrasound (PUS) and quality of life (QoL) was assessed. Operation was performed under regional anaesthesia.A transverse full thickness incision 4-5 cm wide was made in the posterior vaginal wall below the hysterectomy scar. Use TOT instrument (Gynecare Worldwide, Ethicon, USA), the needle insertion and path was around ishiopubic ramus to the adductor longus tendon. We perform this procedure on the both sides.The tape was secured to the vaginal vault and also remnants of the lateral cardinal complex to suspend the vagina.Lastly the vaginal incision was closed. A urinary catheter was inserted for duraation of 12 H. Patients were followed up to 6 months after surgery.
Results: the patients age were 61 and 68 yuears,operation time were 30 and 36 min.,blood loss were 50 and 60 ml,patients were discharged within 24 hours after surgery.Cure of vaginal vault prolapse was assessed clinically,PUS showed reduction in movement of the pelvic floor.Tape rejection was no found.Symptoms cure were based on QoL.
Conclusion:with the TOT procedure,understanding of surgical anatomy is essential for the safe and effective completion of surgery.The minimal invasiveness and effectiveness of the TOT posterior procedure in the treatment of vaginal vault prolapse were confirmed.

P 006

Diagnostic hysteroscopy in endometrial carcinoma: is it a safe method?

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Hysteroscopy is an important method of diagnosis of endometrial pathology. Its use in situations of suspicious malign pathology is still controversial. Various studies on the dissemination of neoplastic cells to the peritoneum after hysteroscopy are discordant. A positive peritoneal cytology is usually associated with other adverse prognostic factors, but, in their absence, isn't related to disease recurrence or survival.
In our department the diagnosis of endometrial carcinoma is usually established by hysteroscopy. The existence of a relationship between the diagnosis of endometrial carcinoma by hysteroscopy and the presence of a positive peritoneal cytology was evaluated.
A retrospective analysis was carried out of the charts of 41 women operated for endometrial carcinoma in our department between June 2000 and December 2004 whose diagnosis had been establishd by hysteroscopy with normal saline as distension medium. The average patient age was 66.7 years. 36(87.8%) women had abnormal bleeding. The biopsy was performed with forceps or Versapoint® in 25(61%) cases, curettage in 11(26.8%) cases, and an association of the two in 5(12.2%) cases. The average time between the biopsy and surgery was 54.3 days. Peritoneal fluid was sampled during surgery. The average follow-up time was 18.3 months.
We found 6(14.6%) cases of positive peritoneal cytology. All had other adverse prognostic factors associated. Although the above results point out the safety of hysteroscopy for the diagnosis of endometrial carcinoma our numbers are very small to be conclusive.

P 007

The risk of iatrogenic ureteric lesion in laparoscopic surgery

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OBJECTIVE: To describe the circumstances of development, diagnostic approach and treatment of iatrogenic ureteric lesions after laparoscopic surgery.
MATERIAL AND METHODS: 19 patients with iatrogenic trauma of the ureter after laparoscopic surgery were managed by our team.
RESULTS: The time to diagnosis ranged from 1-3 month. These injuries were related to gynaecological surgery in 45% of cases, gastrointestinal surgery in 32% of cases, vascular surgery in 10% of cases, and spinal surgery in 13% of cases. The two lesions identified intraoperatively were treated immediately with success. In the case of lesions identified secondarily, first-line endourological treatment was performed in 56% of cases with a good result without reoperation in only 28% of cases. Three patients required reoperation with 66% of satisfactory results and two patients were treated by nephrectomy.
CONCLUSION: Intraoperative difficulties and limited experience of laparoscopic surgery are the factors most frequently identified in iatrogenic ureteric lesions. The time to diagnosis has a considerable impact on the modalities and results of management.

P 008

Pain in office hysteroscopy

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STUDY OBJECTIVE: The main limitation of the office hysteroscopy is pain and low patient tolerance.
The aim of the present study was to evaluate the level of pelvic pain in outpatient diagnostic hysteroscopy and the influence of menopausal status nulliparity, or the menstrual cycle phase.
MATERIAL AND METHODS: This prospective study, performed from January to June, 2004, included 246 patients referred with different indications for diagnostic office hysteroscopy.
The technical procedure was performed by a means of a 4 mm traditional optic Hamou I Storz with a 5 mm thick outer diagnostic sheath.
In all cases the hysteroscopic procedure was completed and the level of pain was rated according to a 0-10 visual analogue scale (0= no pain; 1-3=mild pain; 4-7= moderate pain; 8-10= severe pain)

Patient characteristics	
Mean age (years)	50.5±11.6
Nulliparous (%)	18.7%
Menopause (%)	48.8%
Ages from menopause (years)	9.9±8.7
Proliferative phase (%)	33.3%
Secretory phase (%)	66.7%
Pharmacological preparation	24%

RESULTS: The mean±SD pain score was 4.5±2.9 and there were no statistically significant differences between menopausal and no menopausal women (4.6±2.9 vs 4.3±3.0) or patients in different phases of the menstrual cycle (4.5±3.1 vs 4.2±2.9). Nulliparous women experienced a higher level of pain (5.2±3.1 vs 4.2±2.9) with statistically significant differences.

CONCLUSION: The level of pain experienced by our patients during office hysteroscopy was mild-moderate with no differences between the groups studied excepting nulliparous women.

P 009

Intrauterine synechiae causing miscarriages

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A 33 year old woman gravid 3, para 1 presented to Reproduction Unit following 2 consecutive spontaneous and complete abortions on the first 12 weeks of pregnancy. There was no past medical, surgical, obstetric or gynaecological history of note.
A transvaginal ultrasound scan revealed the presence of a continuity solution in the middle of the uterine cavity (Fig.1).
A hysteroscopy procedure was recommended and a muscular synechiae was diagnosed and treated pressing with the top of the Hamou I hysteroscope (Fig.2, 3).
The study of both parents was completed and results were negative (hormone profile, viral screen, karyotype, autoimmune screen and antiphospholipoid syndrome screen)
6 months after the procedure, patient became pregnant spontaneously with a vaginal birth at 40 weeks of gestation.

P 010

Vaginohysteroscopy with saline solution versus CO2 hysteroscopy

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STUDY OBJECTIVE: To evaluate the feasibility of the vaginoscopic approach for outcome continuous saline flow hysteroscopy in terms of a successful procedure over the traditional CO_2 technique requiring the use of a speculum and tenaculum.
MATERIAL AND METHODS: This retrospective study included 236 referral patients with different indications for diagnostic outpatient hysteroscopy from June 2004 to June 2005. Hysteroscopy procedures were completed in 217 cases (defined as adequate inspection of the canal and endometrial cavity) and no local or general anaesthesia was made in any of the patients.
The technical procedure was performed by means of a 5 mm CO_2 traditional Hamou I hysteroscope (Storz. Germany) (Group A) and a 5 mm Bettocchi rigid hysteroscope (Storz. Germany) with saline fluid for distension (Group B).
RESULTS: There were no differences between groups in terms of age, parity, menopausal status, ages from menopause and hysteroscopy indications.
The mean age of women in both groups was 50.2 years of age (range 21-85).
Within group B the presence of cervical dense adhesions and stenosis was significantly higher (42.6% vs 20.7%; X^2 $p<0.05$).
The percentage of those who completed the examination was 89.6% for group A and 95.1 % for group B, with no statistically significant differences (X^2 $p=0.13$).
CONCLUSION: Hysteroscopy with the vaginoscopic approach is an ideal method for outpatient hysteroscopy. It is feasible, obviating the need for cervical dilatation in most cases because of the ability to perform minor procedures accessing the uterine cavity.

P 011

Thermo ablation of the endometrium for menorrhagia without preparation, using a thermal balloon

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Menorrhagia is a significant problem for otherwise healthy women, with approx 33% of all menstruating women suffering heavy periods. Surgical treatment of heavy menstrual bleeding often follows failed or ineffective medical therapy although it is also used as a first-line therapy. Traditionally these women underwent hysterectomy. Since the mid- 1980's, endometrial ablation and resection techniques have been introduced. Recently, a number of 'blind' endometrial ablative procedures utilizing various energy sources have been developed that do not require skillful hysteroscopic surgery.
We sought to evaluate the effectiveness of day-case CavatermTM plus thermal balloon endometrial ablation in the treatment of therapy-resistant menorrhagia. This prospective study included 300 patients with a mean age of 41 years, mean parity of 2.1 and mean duration of menorrhagia of 3.2 years, operated at Princess Royal University Hospital in London, UK between April 2002 and April 2005. A 6-mm diameter CavatermTM plus catheter with a silicone balloon at its tip was used. The ablation time was 10 minutes at a temperature of 78°C. No procedure-related operative or immediate postoperative complications were encountered. The mean follow up period was 19 months (range 6-24 months). The amenorrhea-hypomenorrhea rates at the various follow up periods ranged between 84% and 93%. At the end of follow up, 93% of patients were satisfied with the procedure. We conclude that CavatermTM plus is a safe and effective treatment for menorrhagia and has good patient acceptability.

P 012

The safety of thermal coagulation in the treatment of endometriosis

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Introduction: The helica thermal coagulator is a new instrument that combines low pressure helium gas with electrical power and is used for the treatment of endometriosis. As the depth of penetration is only 1.1mm, the instrument can be used to treat endometriosis near the ureter or on the bowel.Any tissue contact that occurs carries less potential foe unwanted damage, which appears to make the technique safer than electrocautery or laser.
Study Objective: To assess the safety of the Helica Thermal Coagulator in the laparoscopic treatment of endometriosis
Design, settings and patients: Three hundred and fifty women with endometriosis, a retrospective, observational study in Princess Royal University Hospital, London, UK.(January 2002-January 2005)
Results: Three hundred and fifty women with endometriosis were treated laparoscopically with the Helica Thermal Coagulator .68% were nuliparous. In a further 25% of patients, dyspareunia was the major problem. According to the revised American Fertility Classification: 65% had stage 1 disease, 17.5% had stage 2 disease, 5% had stage 3 disease and 12.5% had stage 4 disease. No major complications occurred in the patients treated with the probe without the cutting end. However, one patient had a vagina perforation from the cutting probe. No patients had bladder, ureteric or bowel perforations. When seen for follow up 12 months later, no major complications were reported and the success rate was 86% (women feeling less pain than before the operation).
Conclusion: The Helica Thermal Coagulator is a safe device for the treatment of endometriosis.

P 013

Introduction of laparoscopy in the management of ectopic pregnancy

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The objective of this retrospective study was to review 65 cases of ectopic pregnancy managed from January 2001 to December 2004 in the Gynecology Departement at Alexadra Hospital.
All operating findings, surgical data and postoperative patients outcome were collected prospectively over this 4 year period. The magority of the patients underwent surgical treatement: 64 (98,4%). Only 3 women (4,6%) were treated conservatively with methotraxate according to our protocol. Thirty-four women (52,3%) underwent laparoscopic management, while the rest 30 (46,1%) were treated with open laparotomy. The main indication for the choice of open surgery was the surgeon's incompetence in laparoscopic surgery: 29 cases (44,6%).
Of the 34 cases treated by laparoscopy, salpigectomy was performed in 21 women (61,7%) whilst 10 women (29,4%) underwent salpigotomy without suturing. There was a woman with ovarian ectopic pregnancy treated successfully by laparoscopy and two other women who had had further treatment with methotrexate after laparoscopic surgery. Five women required adhesiolysis, two women underwent bilateral salpigectomy due to previous obstetric history and two women underwent laparoscopic myomectomy intraoperatively.
The estimated blood loss, the length of hospital stay and the patient's mobilization was in the advantage of the laparoscopic treated group. All patients had further follow-up with hCG titre measurement one week postoperatively.
We concluded that skilled endoscopy teams can provide safely and efficiently laparoscopic management for ectopic pregnancy in Gynecological Units.

P 014

Two years experience with a bipolar electrode in endometrial pathology

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The objective of this study was to evaluate our initial experience with bipolar electrode (Versapoint Johnson & Johnson) for trancervical surgery.
Forty procedures with bipolar electrode in normal saline dispersion fluid were performed between 2003 and 2004. We used a 5,5mm Carle Storz operative hysteroscope and Versapoint system with bipolar electrode (twizle, springle). The majority of patients had preoperative treatment with GnRH-analogs aiming to thinning of the endometrium and better view. General anesthesia was employed.
Polyps constituted the commonest pathology treated by Versapoint: 29 cases (72,4%). They were dissected and excised separately in one or several different parts. In 5 patients (12,5%) intrauterine septa of different size were dissected with mild difficulty. Submucous myomas of maximum diameter of 25mm were evaporated in six women (15%). Lastly intracervical and intrauterine adhesions were successfully dissected in 4 cases (10%). Only one complication was reported in our sample: perforation of the uterus in a patient with intrauterine adhesions treated conservatively without any further implication to the patient.
Versapoint bipolar system constituted a safe and effective operative tool in the management and treatment of endometrial pathology.

P 015

Office hysteroscopy evaluation in patients treated with tamoxifen for breast cancer

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Study Objective: The aim of this study was the evaluation of Office Hysteroscopy follow up of patients treated with tamoxifen.
Methods: We examined 62 women aged less than 65 years old (mean age: 47 years) who were in treatment with tamoxifen as adjuvant therapy for breast cancer.In all patients the thickness of the endometrium was more than 4 mm as it was found in vaginal ultrasound. In this study it was considered also: duration and dosage of therapy, symptomatology, hystreroscopic findings and the histology of endometrium. In all cases we used Continuous Flow Bettocchi Operative Hysteroscope size 5 and normal saline for dilatation.As operative instruments we used forceps and scissors .In all cases biopsies were taken. No patient had either local or general anesthesia.
Results: We observed 38 patients with simple endometrial hyperplasia,15 patients with polypoidal appearance of the endometrium,7 patients with polyps (thickness of the endometrium was between 7-8 mm).
2 patients with submucous myomas (thickness of the endometrium was 10 mm).There is small agreement (positive predictive value), between vaginal ultrasound and hysteroscopical – histological findings when thickness of the endometrium is less than 7 mm.
Conclusion: Office Hysteroscopy follow up, has to be performed in patients treated with tamoxifen, as a first choice procedure after onset of therapy.

P 016

Abdominal pregnancy as managed by laparoscopy

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The uncommon diagnosis of an abdominal pregnancy is made once per 10000 births. About 1% of all ectopic pregnancies appear with a primary or secondary peritoneal implantation. To the authors`best knowledge, this is the first case of an early abdominal pregnancy with unusual pedunculated implantation, managed by operative laparoscopy. The most frequent preoperative misdiagnosis in this situation is tubal pregnancy. Improved recognition of ectopic pregnancy by quantitative ß-human chorionic gonadotropin determination and transvaginal sonography followed by laparoscopy has led to earlier treatment of abdominal pregnancy, thus preventing possible complications of late presentations.

P 017

Severe post partum hemorrhage treated by hysteroscopy

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Hysteroscopy is useful in the management of uterine bleeding. We present a case of severe recurrent post-partum hemorrhage that was treated via hysteroscope.
A 21 years old lady attended the emergency room complaining of severe post-partum hemorrhage.

She had a cesarean two weeks ago for placental abruption, she had delivered a 28 weeks fetus, who died from prematurity soon after. Since then she had been admitted twice to the same hospital for severe post-partum hemorrhage. Each time she had blood transfusion and oxytocin plus methergin and antibiotics, they also perfomed a curratage on her in the second admission. When she started bleeding for the third time she was referred to our hospital.
Her hemoglobin was 6.8 gr/dl, blood coagulation tests were normal. Bp=90/65mmHg, PR=96. Transabdominal ultrasound of uterus was normal.
Prostaglandine F2α infusion was started, but we stopped it because of side effects, We put a foley catheter inside the uterus and filled it with 40 ml of normal saline, which was kept there for 5 days, then it was removed. Two days later she started bleeding heavily again. We performed a hysteroscopy that showed no retained placental tissue inside the uterus, endometrium was atrophic, cesarean scar was very fragile and bleeding. We cautherised whole length of cesarean incision scar tissue using resectoscope.
post operative period was uneventful. Patient was discharged five days later with no bleeding, After 2 months she is well.
We concluded that hysteroscopy could be used in the management of post-partum hemorrhage.

P 018

Laparoscopic myomectomy: a safe alternative to laparotomy

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OBJECTIVE: To evaluate the safety and feasibility of laparoscopic myomectomy. MATERIALS AND METHODS: 101 women underwent laparoscopic myomectomy. The main indications for surgery were: pelvic pain, abnormal bleeding not responding to medication, infertility and bulk symptoms due to fibroid size. The mean age of women was 37,1 years (range 19-47 years) and the mean fibroid diameter was 5,2 cm (range 2,5-13,5 cm). RESULTS: 63 patients had intramular, 29 had subserous, 5 had pedunculated and 4 patients had broad ligament fibroids. The mean operating time was 102 min. The uterus was repaired with interrupted sutures(intracorporeal or extracorporeal knot tying were used), and the excised leiomyomas were morcellated. The intraoperative blood loss ranged between 40-700 mls. 3 patients required blood transfusion. 2 cases were converted to laparotomy (one due to extensive adhesions and the other due to techniacal difficulties). One patient had postoperative fever > 38,5 C. 5 patients were discharged the same day (all with pedunculated fibroids), 90 patients were discharged the 1st and 5 patientnts the 2nd postoperative day. The laparotomy cases were discharged the 3rd postoperative day. CONCLUSION: Laparoscopic myomectomy is a safe alternative to laparotomy method of surgical management of leiomyomas.

P 019

Is there any role for short-term conservative treatment with antibiotics before laparoscopic drainage of tubo-ovarian abscesses? A report of two cases

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Introduction. The management of tubo-ovarian abscesses is still controversial and therapeutic options range from simple treatment with intravenous antibiotics to primary laparotomy. The current widespread application of laparoscopy in the treatment of tubo-ovarian abscesses has led to a shift from conservative treatment to immediate laparoscopic management during the first 24 hours of hospitalisation. We report two cases of tubo-ovarian abscesses treated initially with short-term intravenous wide-spectrum antibioticS followed by successful laparoscopic drainage of the purulent content.
We report one case of a 42 year-old patient whO became septic and received intravenous widespread antibiotics prior to laparoscopic drainage and of another case of a 38 year-old IUCD user with an ovarian abscess who also received short-term antibiotics before laparoscopic treatment
Conclusions. Laparoscopic treatment is, nowadays, feasible in cases of tubo-ovarian abscesses. Conservative antibiotic short term (5-10 days) pre-treatment seems to offers certain advantages: a) an attempt to control the inflammation conservatively, so as the patient could avoid surgical intervention, especially in women not desiring to bear children any more, b) a way to improve surgical conditions and the patient's prognosis by limiting the extent of inflammation and, thus, tissue damage during surgical exploration and management.

P 020

Adhesions after hysteroscopic surgery and hysteroscopic adhesiolysis: a prospective randomized study

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Background: Post operative intra-uterine adhesions are classified as de novo when they develop at sites that did not have adhesions initially, and as reformed when they redevelop at sites at which adhesiolysis has been performed. We performed two prospective, randomised, controlled studies to assess the efficacy of the auto-crosslinked hyaluronic acid gel (ACP gel) in preventing the reformation of intrauterine adhesions after hysteroscopic adhesiolysis (Study I) and the development of intrauterine adhesions following hysteroscopic surgery (Study II).
Methods: 92 patients with intrauterine adhesions (Study I) and 135 patients with intrauterine myomas or polyps or uterine septa (Study II) were enrolled. In both studies patients were randomized in two different treatment groups: Group A underwent hysteroscopic adhesiolysis (Study I) or hysteroscopy surgery (Study II) plus intrauterine application of ACP gel (10 ml); Group B underwent operative hysteroscopy alone and was considered as control group. The Adhesion Score was calculated for each patient at the entering of the study and 3 months after surgery.
Results: In both studies a significant reduction of intrauterine adhesions at 3 months follow-up was detected in groups A in comparison with corresponding groups B. Staging of adhesions showed a significant decrease in adhesions severity in patients treated with ACP gel.
Conclusions: Auto-crosslinked hyaluronic acid gel significantly reduces the incidence of reformed intrauterine adhesions after hysteroscopic adhesiolysis and the "de novo" formation of intrauterine adhesions after hysteroscopic surgery.

P 021

Total laparoscopic radical hysterectomy(type III) with paraaortic & pelvic lymphadenectomy. A recently reported case in a greek tertiary center

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BACKGROUND: The role of laparoscopy in the management of abdominopelvic malignancies is evolving. Data from new randomized and nonrandomized controlled trials demonstrate that laparoscopic surgical staging has equal efficacy (lymph node counts, disease free survival) compared to traditional open cases and can be safely performed in selected patients.
MATERIALS AND METHODS: We report a case of laparoscopic radical hysterectomy and lymphadenectomy performed in a Greek tertiary center at the end of last year in a 44 yo G1P1 female with squamous cell carcinoma of the cervix, stage IIA. After a thorough preoperative assessment, informed consent was obtained and a specialized surgical team was assembled and performed the surgery.
RESULTS: A laparoscopic radical hysterectomy type III with para-aortic and pelvic lymphadenectomy was carried out. Nineteen nodes were retrieved two of which (2/19) were positive for metastasis. She suffered a left lower extremity venous thrombosis for which she underwent standard DVT treatment. The patient required only one analgesic suppository for postoperative pain control and remained afebrile throughout her hospitalization. She received adjuvant chemoradiation due to risk factors and is now under a standard surveillance schedule.
CONCLUSION: The performance of this procedure in a tertiary center in our country is feasible and safe provided there are trained surgeons in advanced laparoscopic oncologic/pelvic surgery. Laparoscopic surgical staging, is gaining steadily wide acceptance by both patients and physicians, throughout the world. To our knowledge a total laparoscopic radical hysterectomy with bilateral paraaortic and pelvic lymphadenectomy has not been previously described in our country.

P 022

Synchronous rectovaginal, full-thickness urinary bladder and pulmonary endometriosis: successful treatment using a laparo-endoscopic approach in a tertiary university medical center

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INTRODUCTION: Extragenital endometriosis is an uncommon condition, yet can affect almost any organ system. Disease involving multiple distant sites is extremely uncommon. We present the first cited case of coexistent triple site extragential endometriosis in a 31yo woman.
MATERIALS AND METHODS: Tertiary university-based Medical Center. A 31-year-old female presented with catamenial dysuria, pleurisy associated with spontaneous pneumothoraces of one-year duration and longstanding history of pelvic pain. MEDLINE Literature Search from 1966 to date using KEYWORDS "extragenital", "endometriosis", "pulmonary", "bladder" etc yields no publications to date for coexistent triple site extragenital endometriosis. A multidisciplinary surgical team was assembled and performed a single operation.
RESULTS: Office cystoscopy confirmed a full thickness bladder endometrioma. Rectovaginal examination revealed nodularity and indurated rectovaginal space. Speculum examination was notable for an endometrioma in the posterior vaginal fornix. The patient was brought to the Operating room by a gynecologic, urologic and thoracic surgical team. Video-assisted Thoracoscopic Surgery confirmed the diagnosis of pleural endometriosis which was fulgurated, followed by pleurodesis. Operative Laparoscopy was then carried out and along with simultaneous cystoscopy a segmental bladder wall excision and repair was performed. Finally disc excision of rectal endometriosis and sgmental posterior vaginectomy was performed. Twelve months after surgery and without no hormonal manipulation, the patient remains symptom-free.
CONCLUSION: Extragenital endometriosis may coexist in multiple sites. A carefully planned multidisciplinary approach is warranted in cases refractory to medical treatment or alternatively to more invasive procedures such as abdominal hysterectomy, bowel resection or thoracotmy all of which carry a greater morbidity for the patient.

P 023

A new method of sling procedure in stress urinary incontinence and genital prolapse

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Nowadays surgery's efficacy for stress urinary incontinence and genital prolapse is very high, but the problems of safetiveness of the procedure still remain. The effectiveness of these procedures is based on full combined correction of all pelvic floor defects.
Objective of our study was to develop high-effective miniinvasive and safe sling surgery for combined correction of stress urinary incontinence and genital prolapse.
The new instrument for surgery was worked out on the basis of more than 10-year experience of antistress and genital prolapse surgeries. We have made an attempt to work up a procedure with maximum efficacy, safetiveness, with an opportunity to consider an individual features of the patients, that we hope will enhance the quality of medical services. This procedure is another step in the development of antistress and prolapse surgery, and gives an opportunity for surgeon to perform transobturator or retropubic sling procedure and correct genital prolapse if necessary and to select various materials of different shape as implants.
16 new procedures were performed from 2004 till now. We have analyzed intraoperative data, early and late postoperative complications. Our first results showed new procedure to be high-effective and safe.

P 024

Endoscopic methods for treatment of patients with disseminated genital endometriosis

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We examined and treated 800 patients with mean age of 41±3,5 yrs with disseminated genital endometriosis. Purpose – to develop fundamentalis of surgical treatment of disseminated forms of genital endometriosis and determine the role and place of endosurgery in the treatment of this condition.

Clinical and instrumental examinations of 800 patients(transvaginal and transrektal ultrasonic examination, hysteroscopy with separate diagnostic curettage, colono- and sigmoscopy, excretory urography and cystoscopy, retrograde urethropyelography, laparoscopy and laparotomy, morphological analysis) with disseminated endometriosis helped select the patients surgical treatment. 240 patients with disseminated endometriosis, involvement of the adjacent organs, and cellular spaces of the pelvis were subjected to surgery on the internal genitals, distal portions of the large intestine, and urinary organs. 560 patients were subjected to radical (radical laparoscopi surgery included intrafascial histerectomy using loop ligature -27.28%; supracervical hysterectomy – 12.7%; intrafascial Semm hysterectomy – 2.71%) and organ-plastic endoscopic operations(39.57%).
The developed methods of surgical treatment of this patient population are effective and little traumatic. The incidence of complications after operations performed through the traditional approach (laparotomy) was 9.6% and after radical endoscopic interventions 0.37%.
Conclusion: Detection and radical removal of all foci of endometriosis foci, strict adherence to the sequence of surgical steps during interventions on the genital and adjacent organs, adequate correction of intraoperative and prevention of postoperative complications guarantee effective treatment of patients with disseminated forms of genital endometriosis.

P 025

Place of laparoscopic hysterectomy in treatment for benign uterine diseases in perimenopausal women

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Approximately 40% of perimenopausal women suffer from benign uterine diseases (benign endometrial hyperplasia, leomyoma, adenomyosis). The rate of combined benign uterine disorders is over 50%.
60 Perimenopausal women (45 years old and up to 2 years of menopause) with benign uterine process (recurrent endometrial hyperplasia, leomyoma, adenomyosis) paticipateted in the study. The mean age was 48,3 years, range 45-56.
48 patients (63,3%) underwent hysterectomy: 35 (58,3%) – laparoscopic and 13 (21,6%) laparotomic.
Indications for hysterectomy were combined uterine diseases, submucosis leomyoma, leomyoma when uterine size was 7 weeks and over, adenomyosis, recurrent endometrial hyperplasia. When uterine size exceeded 12 weeks laparotomic hysterectomy was performed.
Abdominal interventions in anamnesis in 7 cases were not contraindications for endoscopic technique.
Laparoscopic hysterectomy is an operation of choice for patients with combined uterine disorder or recurrent endometrial hyperplasia when uterine size does not exeed 12 weeks.

P 026

Endoscopic treatment of adenomyosis in infertility patients

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26 – 59% of patients with adenomyosis suffer from infertility, which is rather difficult to treat. Even, the IVF procedure is less effective in such the patients.
Since 2002 we examined and treated 17 patients with adenomyosis and infertility. To assess the condition of uterine cavity we perfomed office hysteroscopy: in 8 patients with secondary infertility and 1 patient with primary infertility intrauterine synechiae were found.
All the patients underwent laparoscopy, during which besides dye insufflation, adhesiolysis, coagulation of endometriotic lesions we performed drilling of the uterus with Ho-YAG laser in 8 patients (I group) and laparoscopic ligation of the internal iliac arteries in combination with drilling of the uterus in 9 patients with severe diffuse adenomyosis and intrauterine synechia (II group).
Postoperatively all the patients recieved hormonal treatment: I group – gestagens in the luteal phase of menstrual cycle, II group - GnRH analogs for 3-4 months. In the II group of patients intrauterine synechiae were divided during hysteroscopy after the last injection of GnRH analogs.
The follow-up period was 6-36 months. The patients noted the relief of pain syndrome, normalization of menstrual bleeding. During ultrasound examination we noted the decrease of uterine size. 3 (37,5%) patients of the I group become pregnant, 2 patients (22,2%) of the II group become pregnant after IVF procedure.
Thus, endoscopic drilling of the uterus with Ho-YAG laser in combination with laparoscopic ligation of internal iliac arteries can be a good clinical practice for treatment of adenomyosis in infertility patients.

P 027

Laparoscopic evaluation following failure to achieve pregnancy after intrauterine insemination

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OBJECTIVE: To assess the diagnostic benefit of laparoscopy in infertile women thought to be at low risk for altered pelvic anatomy.
DESIGN: Retrospective chart review.
SETTING: Tertiary care academic medical center.
PATIENT(S): 127 Infertile patients who underwent laparoscopic evaluation of the pelvis failing to conceive after five intrauterine inseminations (IUI) with normal hysterosalpingography (HSG).
INTERVENTION(S): Diagnostic and/or therapeutic laparoscopy.
MAIN OUTCOME MEASURE(S): Presence of pelvic pathology and predictors of pelvic disease.
RESULT(S): Although the hysterosalpingogram was read as normal in all women, endometriosis stage I-II was found in 64 (50%) patients, stage III and stage IV in 4 (3%). Adhaesions was diagnosed laparoscopically in 22 (17%) patients, and distal tubal disease in 26 (20%). All of this abnormalities were directly treated by laparoscopic intervention.
The time between HSG and laparoscopy was positively correlated with appearance of distal tubal disease and pelvic adhaesions.
CONCLUSION: Laparoscopic findings could lead to a change of treatment decisions in infertile couples with normal hysterosalpingography.

P 028

Laparoscopic prognoses for fecundity following unexplained infertility

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OBJECTIVE: To clarify whether the benefits of laparoscopic examinations of patients with unexplained sterility is dependent on the duration of infertility.

STUDY DESIGN: This was a retrospective study of 117 fully investigated infertile couples who had been infertile for 1> year and were followed for 1 year post laparoscopy. The couples were divided into two groups according to their duration of infertility(<5,>5), and their characteristics were studied in related to pregnancy.
RESULTS: Both groups of infertile women had similar characteristics. Endometriosis and pelvic adhesion were found with similar frequency regardless of the duration of infertility. Infertile women with increased adhesion, however, more tended to conceive compared to patients with lesser adhesion. Univariate analysis using Kaplan-Meier curves revealed that infertile women with >5 years of infertility were less likely to conceive than women with <5 years of infertility(log rank test p=0.003).
CONCLUSION: The fecundity of infertile women with bilateral tubal adhesion following laparoscopic adhesiolysis was higher than that of women with unilateral tubal adhesion or normal tubes. This supports the benefits of laparoscopic assessments, and it is therefore desirable that patients with unexplained sterility undergo laparoscopic examination as early as possible.

P 029

Laparoscopy in the evaluation of women with ascites: an invaluable minimally invasive diagnostic tool

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Aim of the study: In this study we attempted to evaluate laparoscopy as the final diagnostic tool in all cases with ascites that remained undiagnosed after an extensive work-up.
Patients and methods: We included 7 cases with ascites and absence of any obvious focal pathology. Laparoscopy was performed in all cases and directed or random biopsies were liberally taken and were send for histology.
Results: Median patient age was 36 years (range 27-78). Five cases presented with a recent diagnosis of ascites. One 27 year-old patient was admitted with persistent ascites for a second-look laparoscopy, one year after a diagnosis of PID was made. The last patient developed ascites a few days after laparoscopic adhesiolysis. Preoperative CA-125 levels were elevated in all cases. At laparoscopy the former 5 cases were found with multiple miliary and larger deposits resembling a widespread malignant tumor. Nevertheless, histology of the biopsies taken confirmed the presence of malignancy in only 3 cases. The other two cases were found with peritoneal tuberculosis! The patient with persistent ascites also had multiple deposits that were proved to be a primary malignant peritoneal mesothelioma. The last patient had no obvious pathology, the ascites was presumably a result of allergic reaction to methylene blue and resolved spontaneously in a few days. Peritoneal fluid cytology was reported negative for malignancy in 4/7 cases.
Conclusions: Laparoscopy can be a very useful minimally invasive diagnostic tool in cases with ascites and no obvious focal pathology. In cases with widespread malignancies precise biopsy-proven diagnosis is mandatory for further management decisions.

P 030

An analysis of the efficacy and cost effectiveness of the thermal ligating shears in gynaecological laparoscopic surgery

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Background: To establish the safety and efficacy of the Thermal Ligating Shears (TLS) (Starion Instruments Corp., Saratoga CA, USA) in performing various laparoscopic gynaecological procedures. This equipment was evaluetd for advantages in term of operating time, bleeding and morbidity, and costs.
Materials and Methods: Various laparoscopic procedures such as adhesiolysis, cystectomy, endometriosis resection, appendicectomy and salpingectomy were carried out. The patients were randomized into two groups, one using the TLS and the other using convential ultrasonic shears. The mean operating time, blood loss and complication rates were recorded. Hospitalization time and a simple cost analysis was also carried out. The two groups were compared using the Student's t test.
Results: The mean operative times, blood loss and complications were not significantly different between these two groups. There was no differnce in hospitalization time but the cost of using the TLS was significantly lower as compared to the ultrasonic shears.
Conclusions: The TLS provides a means for the operative surgeon to safely perform simple gynaecological laparoscopic procedures alone without significantly increasing operative time or morbidity, yet at a fraction of the cost of the Harmonic Scalpel.

P 031

Infertility due to retained fetal bone: Role of microhysteroscopy in diagnosis and management

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Background: Intrauterine retention of foetal bones may complicate miscarriage and termination of pregnancy (TOP). Often asymptomatic, it could cause secondary infertility, its diagnosis being fortuitous during infertility investigation.
Diagnosis and treatment need special precautions to avoid potential complications. We report on the use of Microhysteroscopy as diagnostic and treatment tool and review commonly used diagnostic and therapeutic methods highlighting merits and pitfalls.
Setting: Centre of Reproductive Medicine, Minimally Access Surgery Training Unit, St. Bartholomew's and The Royal London Hospital NHS Trust, London, UK
Cases: Three women aged 25, 34 and 40 years old were diagnosed intrauterine foetal bones during fertility investigation. Traditional primary diagnostic methods (transvaginal ultrasound, hysterosalpingogram) varied in accuracy for detecting the abnormality. Microhysteroscopy, using the Gynecare Versascope Hysteroscopy System (Gynaecare, Johnson & Johnson, Somerville, NJ, 08876, USA) allowed successful diagnosis and treatment simultaneously.
The surgical procedures undertaken were uneventful, cervical dilatation was not required and hard, bony coral-like fragments were visualised and removed under direct vision using a 2 mm of diameter micro-grasper.
Histological examination confirmed the presence of bone fragments in all 3 cases.
Fertility was restored naturally in one case.
Conclusion: Intrauterine retention of foetal bones should be suspected in infertile women who previously had miscarriage or TOP. If echogenic lesions are discovered in the uterine cavity during primary investigations, the use of Microhysteroscopy allows the maximum performance in diagnosing and treating these lesions whilst minimizing the risk of complications and patient discomfort.

P 032

Ovarian endometriosis associated with ovarian cancer and endometrial polyps

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Objective: To determine the prevalence of ovarian cancer and endometrial polyps in women with moderate and severe ovarian endometriosis.
Methods: A retrospective analysis of 667 cases of moderate and severe endometriosis laparoscopically and histologically confirmed during the period 1998-2004.
Results: Ovarian cancer was diagnosed in thirteen cases of ovarian endometriosis (n=13, 1,95%), while an endometrial or endocervical polyp was identified in thirty-five cases (n=35, 5,25%). The mean age of the patients with ovarian cancer (44,5+-13,4) was significantly higher than the age of the patients with endometrial polyps (35,4 + -5.0, p=0,033). One hundred ninety three (n=193, 28.9%) of cases were FIGO stage III (moderate endometriosis) and 473 (70,9%) were Figo stage IV (severe endometriosis).
The incidence of endometrial polyps in the whole group [5,25%(35/667)] was higher than the incidence of ovarian cancer [1,95%(13/667)]. The incidence of endometrial polyps in the group with moderate endometriosis was higher [7,77%(15/193)] than that in cases with severe endometriosis [4,22% (20/473)]. The same results were obtained in the ovarian cancer group (moderate: 3,10%, 6/193, severe: 1,47%, 7/473).
Conclusisons: Both ovarian cancer and endometrial polyps are associated with ovarian endometriosis. Compared to severe endometriosis, moderate endometriosis is associated with higher incidence of ovarian cancer and endometrial polyps.

P 033

Laparoscopic management of the ectopic pregnancy with the ultrasonic scalpel

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Study aim: To evaluate the efficacy and safety of the Harmonic Scalpel (HS) in laparoscopic treatment of ectopic pregnancy.
Material and Methods: From 1999 to 2004, 70 patients were treated for ectopic pregnancies and their medical records were reviewed. We encountered 72 tubal, 4 corneal, 2 ovarian and 2 heterotopic pregnancies. Surgical treatment included salpingectomy or salpingostomy, using electrosurgery, endoloops and, recently, the ultrasonic scalpel. Use of the ultrasonic scalpel for salpingectomy was compared to electrosurgery and endoloops.
Results: Use of the HS resulted in reduced operative time, less operative manipulation and minimised tissue damage. There is no surgical smoke and tissue carbonisation and surgeons find it easy to use and safe as an operative modality.
Discussion: Laparoscopy is the first choice of surgical management of ectopic pregnancies. Ultrasonic scalpel is associated with reduced operative time, reduced surgical manipulation and surgeons find it easy to use and safe for the patient. The Harmonic Scalpel is a useful modality in the laparoscopic treatment of ectopic pregnancy.

P 034

Ovarian hyperstimulation syndrome coexisting with ectopic pregnancy: surgical management by minimally invasive approach

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Case Report: A-37-year old woman presented with lower abdominal pain, discomfort and vaginal bleeding after IVF treatment. Abdominal ultrasound scan revealed bulky uterus, thickened endometrium, enlarged ovaries with multiple cysts, and small amount of fluid in the pouch of Douglas. Pregnancy test was positive and blood tests revealed elevated b-HCG, high levels of oestradiol and mild electrolytic changes. Initial diagnosis was mild ovarian hyperstimulation syndrome. However, transvaginal ultrasound scan revealed right tubal ectopic pregnancy coexisting with the OHSS. Surgical treatment was decided bur due to considerable enlargement of both ovaries, the Gynaecological Endoscopy Team considered mini laparotomy safer minimally invasive approach to laparoscopy. Patient underwent surgery and right salpingectomy was performed.
Discussion: All women who undergo ovarian stimulation during IVF, experience enlargement of their ovaries and a complex change in their hormone balance. For up to 4% this can be quite unpleasant with abdominal bloating and pelvic discomfort, but only 1% of stimulated women will require hospital admission. This problem is labelled the "Ovarian Hyperstimulation Syndrome".
Cases of coexisting ovarian hyperstimulation and ectopic pregnancy are rare, and pose a difficult diagnostic problem. The routine attempts at laparoscopic diagnosis and treatment of these pregnancies may prove to be hazardous. When surgical treatment is mandatory and / or unavoidable, mini laparotomy is a safer minimally invasive approach.

P 035

Vesical endometriosis: report of three cases and review of the literature

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Endometriosis is a common gynaecological disease in which endometrial tissue is deposited outside the normal confines of the uterine cavity. It is quite unusual to find endometrium foci within the vesical cavity, this experience representing only 1-2% of all possible locations. Classic presenting symptoms include cyclic irritative voiding symptoms and suprapubic discomfort with or without haematuria. A delay in detection can result in months or years of morbidity. Diagnostic methods employed include transabdominal and transvaginal sonography, CT and MRI scan, laparoscopy and cystoscopy. Both medical and surgical management have been advocated, but surgical extirpation, either with laparoscopy/laparotomy or transurethral resection, is probably more efficacious. Three cases of endometriosis involving the bladder are presented and contrasted in terms of pathophysiology. One of the cases had concomitant deep infiltrating pelvic endometriosis, the second was an isolated case of bladder endometriosis and in the third there was a possible connection with previous gynaecological surgery. A combined approach of surgical excision and suppression with GnRH analogues led to symptomatic relief and long term regression of the vesical lesion. Pertinent clinical images are includ-

ed, contemporary management of this condition is reviewed, and guidelines for diagnosis and treatment are proposed.

P 036

Long-term results after laparoscopic myomectomy in infertile patients: still topic for discussion

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Reproductive surgery is one of basic laparoscopic procedures in our department. In a retrospective analytic study we present long-term reproductive results after laparoscopic myomectomy in infertile women. Between 1993-2003 we used laparoscopy for operation of 289 infertile patient with a diagnosis of an uterine myoma. In our study we also present thorough statistical analysis of collected data. The pregnancy rate after surgery (minimum one year follow-up) was more than 50%. The incidence of Caesarian section in our group is about 40%. We didn’t experienced any uterine rupture in our group. We discuss the influence of risk factors during and after laparoscopic surgery (myoma size and localization, suture vs. coagulation) on the modality of pregnancy termination.We conclude that appropriate surgical technique give very good reproductive results without increasing fetomaternal risks and morbidity.

P 037

See and treat as an office hysteroscopic procedure

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Objective: The aim of the study was to evaluate office hysteroscopy for “see and treat” intrauterine surgery.
Material and methods: In the last three years (2002-2004) we performed 3530 diagnostics and operative intrauterine procedures. 2612 (74%) procedures were diagnostics and 918 (26%) operative. From the number of 918 operative procedures 744 (81%) procedures were performed as a „see and treat“ and 174 (19%) as a resectoscopic surgery under general anesthesia. From the number of 744 „see and treat“ procedures 698 (93,9%) were endometrial polyps resections, 23 (3,1%) pedunculated myomas exstirpations, 12 (1,6%) intrauterine synechias resections and 11 (1,4%) “lost IUD” extractions.
Results: Procedurs were uncomplicated and finished in one setting. Patiens considered 670 (90%) procedures as completely painless, in 41 (5,5%) cases were evaluated by patiens as discomforted and at least in 33 (4,5%) we were unsuccessful and had to complete procedure under general anesthesia.
Conclusion: Using reasonable management (“selection”) of the patients for “see and treat” office hysteroscopy we were able to manage 90% intrauterine pathologies without any discomfort of women.

P 038

Diagnostic hysteroscopy in perimenopausal women

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Diagnostic hysteroscopy is a trully useful tool,that strengthens our ability for precise diagnosis of endometrial lesions.
We present a series of 40 cases,which were performed at the Department of Gynaecology at LAIKO Athens General Hospital.All women,who underwent this diagnostic procedure,were between 45 and 55 years old and they presented to us with meno-metrorrhagias and/or ultrasonographic findings of endometrial thickening.The operation was performed by means of a scope with diameter 2.9 mm.In most of the cases(35) there was no need for dilatation of the cervix and the passage of the instrument was easy. In 5 cases there was a need for cervical dilatation.
In 22 cases a hyperplastic endometrium was revealed.In some of them(10)we found that endometrial polyps co-existed.Submucosal myomata were found in 6 cases.Endometrial polyps were present in 3 more cases without evidence of hyperplasia in the rest of the endometrium.In 5 cases we had the impression of dysplastic or malignant lesions.In the rest 5 cases atrophic endometrium was revealed.
In all these cases our procedure was followed by biopsy. The histologic findings were in agreement with the hysteroscopic picture. Abnormal proliferative endometrium (8 cases), simple hyperplasia without atypia (8 cases), complex hyperplasia without atypia (7 cases), complex hyperplasia with atypia (5 cases), benign adenomatous polyps (13), atrophic endometrium (5 cases), adenocarcinoma (4 cases).
It is undoubtful that diagnostic hysteroscopy should be a necessary step in the management of the endometrial pathology and it can lead us to a more confident every day practice.

P 039

The first case of supernumerary ovary containing endometriosis and atypical cells

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Supernumerary ovary occurs in 1 in 29,000-700,000 gynaecological admissions, it does occur naturally and was first described in 1890. A supernumerary ovary is a third ovary having no connection with the normally located ovary. We report the first supernumerary ovary that contains both endometriosis and atypical cells. It is believed that atypical endometriosis shows proliferation activity intermediate to those of typical endometriosis and ovarian carcinoma, suggesting it possesses a precancerous potential or is most frequently associated with endometriod and clear cell carcinomas. Therefore, women with atypical endometriosis may be at an increased risk of developing endometriosis-associated ovarian cancer. It is also believed that supernumerary ovary is found commonly in association with endometriosis, furthermore supernumerary ovary has higher potential for neoplastic growth than normal ovary.

P 040

A review of laparoscopic hysterectomy in private practice

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STUDY DESIGN: A non randomised prospective study for all patients who were hysterectomy candidates to undergo the laparoscopic technique with conversion when indicated.

Exclusion criteria included malignant disease.
This is an ongoing study involving a single surgeon.
MAIN RESULTS: 311 Laparoscopic Hysterectomies were performed; 47 LSH and 254 TLH procedures. Only 5 procedures had to be converted to laparotomy and the last 35 hysterectomies were performed in a day clinic.
COST: A comparative cost analysis between five hysterectomy techniques was carried out to prove the economic equality of total laparoscopic hysterectomy (The Big Five – 1998). The difference in mean total hospital charges between TLH and TAH was negligible. LAVH proved to be the least cost effective.
COMPLICATIONS: No deaths occurred but 5 ureteric injuries and a single small bowel perforation occurred in the early stages of the learning curve.The incidence and nature of our complications compare favourably to other renowned laparoscopic surgeons and is presented.
INSTRUMENTATION: No stapling technique was used. All pedicles were secured and transected by bipolar coaptation.
A specialised uterine manipulator (Lubbe-Levator) was utilised to perform circumferential colpotomy. This instrument was developed and manufactured in South Africa.
CONCLUSION: Progress of advanced endoscopic surgery in South Africa has been slow. However the technique of TLH should now be offered to South African patients and the technique possibly introduced to gynaecologists in Sub Saharan Africa. The latter, we noticed, has already been addressed with the first African conference in Cameroon in January 2006 in affiliation with the AAGL.

P 041

Transrectal ultrasound guidance for hysteroscopic operations of deeply nested submucosal and intramural myomas and in total Asherman's syndrom

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Objective: Value assessment of transrectal intraoperative ultrasound (TRUS) guidance of hysteroscopic electroresection of myomas that deeply embedded in the myometrium and hysteroscopic synechotiomy in Asherman's syndrom.
Design and materials: Study group-hysteroscopic operations with intraoperative TRUS-submucosal myomas in stage G2 by ESH and intramural myomas (n=43), total Asherman's syndrom.(n=6) Control group- without TRUS- hysteroscopic myomectomy (n=47), synechiotomy in Asherman's syndrom (n=5). Parameters characterizing of hysteroscopic operations, complications, and anatomical results after operation were compared.Statistical analysis Chi2 and t student tests.
Results: When TRUS was used (in contrast to control group) no intraoperative complications were observed and mean time of procedure was decreased: myomectomy (24vs36 min), synechiotomy in Asherman's syndrom (29vs.38min). Statistical significant differences concerned anatomical results assessed after operation: in myomectomy totally remove of myoma was stated in 40 (93%) vs. 35(74,5%) in control group. In cases of total Asherman's syndrom satisfactory anatomical effect after single surgery accompanied by TRUS was obtained in 3(50%) cases vs. 1(20%) in control group.
Conclusions:Use of TRUS assisting hysteroscopic surgery enable continuous sonographic control of working instrument position in uterine cavity, in relation to myometrium and perimetrium also in cases of increasing bleeding that makes visualization difficult. It increases safety of operations, and causes optaimalization of course parameters and anatomical results in cases of hysteroscopic resection of submucosal myomas deep penetraeted myometrium or intramural, and in the advanced Asherman's syndrom.

P 042

The value of cervical infiltration with mepivastesin in diagnostic hysteroscopy: a prospective study

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Aim: To estimate the efficacy of local cervical application of mepivastesin 3% for reducing pain associated with hysteroscopy.
Patients and methods: A total of 220 non pregnant women underwent diagnostic hysteroscopy over a 5-year period (2000-2005). The mean age was 36 years and the indications were: abnormal uterine bleeding, secondary amenorrhea, investigation of missed and habitual abortions and intrauterine evaluation.before first I.V.F. The whole procedure was conducted by injecting mepivastesin 3%. into the cervical tissue at 2 o'clock, 6 o'clock and 10 o'clock on the ectocervix. Immediately, after the procedure all patients were asked to rate the pain they experienced after 15 and 30 minutes.
Results: Fifteen women had been through general anesthesia because of an increased anxiety associated with the procedure. Two hundred and five women tolerated the procedure very well, with no major changes of blood pressure, heart rate or central nervous system symptoms. The effect of the local anesthetic agent lasted for at least 15 minutes and after 20 minutes all patients felt no pain.
CONCLUSIONS: Local anesthetic mepivastesin is a reliable and effective method for reducing pain. The absence of the side effects have proved that hysteroscopy can be easily and safely performed.

P 043

Three-dimensional hysterosonography for the study of the endometrial cavity in infertile women: comparison with diagnostic hysteroscopy

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Aim: Assessment of endometrial pathology by the combined use of 3-D-hysterosonography and hysteroscopy before any treatment for assisted reproduction.
Patients and methods: A total of 90 infertile women undergoing hysteroscopy were included in this study. Each patient underwent 3-D hysterosonography a day prior to hysteroscopy on the 8th day of the cycle. The patients were premenopansal (mean age 34). Comparison of the ultrasound findings with the diagnosis of hysteroscopy was conducted.
Results: Hysteroscopy detected 25 submucous myomas, 38 endometrial polyps, 12 cases of intrauterine synachiae and 15 women had no abnormalities in the uterine cavity. Good quality 3-D images were obtained in all patients. Three -D- hysterosonography reached sensitivity 97,5% and specificity 100%, respectively. In one patient, 3D hysterosonography didn't reveal a submucous myoma and in another case didn't depict a polyp due to fundal fibroid distorting the uterine cavity.
Conclusions: The use of 3D ultrasonography after injection of saline solution can be effenciently used for detection of endometrial pathology and to follow up of the patients undergoing hysteroscopy. Further multicenter studies are required to determine the potential and cost effectiveness of the routine use of this rapidly developing technique.

P 044

The use of a bipolar electrosurgical system to remove intrauterine polyps by hysteroscopy

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OBJECTIVE: To ascertain the therapeutic efficiency and accuracy of hysteroscopic resection of endometrial polyps with resectoscopy in combination with curettage.
SETTING: University hospital.
DESIGN: Retrospective study.
MATERIAL AND METHODS: From 2000 to 2005, 105 patients with hemorrhagic endometrial polyps and per menopausal metrorrhagia were treated with hysteroscopic resection and complementary curettage in our department.
RESULTS: The major advantages were ease of removal of tissue fragments through the bipolar electrosurgical system (versa point) and the use of saline solution. The mean operating time was 10 minutes for the removal of endometrial polyps and another 10 minutes for the completion of the curettage (total time 20 minutes). All procedures were uneventful and all women returned to their home the same day.
CONCLUSION: Hysteroscopic resection of endometrial polyps with resectoscopy in combination with curettage is sufficient for the extraction of endometrial polyps and the detection of other pathological disease of the endometrium. As a technique is faster and easier to perform and it can be expected to result in fewer fluid related complications. As for the curettage, is an effective procedure for the detection of severe endometrial disease. Hysteroscopic polypectomy in combination with curettage is regarded as the optimal therapy and the removal of the endometrial basalis in the endometrial polyps origin area.

P 045

Diagnostic accuracy of laparoscopy in endometriosis: evaluation of visual diagnosis and histological findings

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Introduction: Biopsy specimen of peritoneal lesions suggestive of endometriosis provides histological confirmation in 3.1%-100% cases depending on lesion type and location.
Objectives: The purpose of this study was to access the diagnostic accuracy of laparoscopy for endometriosis by correlation of visual and histlogical findings.
Material & Methods: To investigate this, total 67 records were obtained from patients with laparoscopic surgery for endometriosis. Patients were audited prospectively over a period of 6 months from September 2004 to February 2005.
RESULTS: All 67 patients were visually diagnosed as having endometriosis. The mean age of the patients was 33.97 years (CI 32.87, 35.07). The biopsies from suspected endometriotic sites with or without ovarian cysts were obtained in 66 patients. Endometriosis was confirmed histologically in 54 patients (81.8%).Negative biopsy results were found in 12 patients (18.2%). The sensitivity for the visual versus histological diagnosis of endometriosis was 81.3% .The sensitivity increased to 93.3% with combined positive biopsy and ovarian cyst histology results. 32 patients (74.4%) had confirmed histology out of 43 patients with Stage I-II disease whereas 22 patients with Stage III-IV had +ve result in 95.6% with –ve histology in only one case (4.3%).
CONCLUSION: This study demonstrated that laparoscopy should be considered as a gold standard for the diagnosis of endometriosis. A consistence of visual versus histologically diagnosed endometriosis has shown a step towards" see & treat management" as it is safe, less time consuming and cost-effective. However further validation is required via multi-centre prospective randomised controlled studies.

P 046

Is day case laparoscopic surgery justifiable in the treatment of endometriosis? Potential benefits in effective health care service

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Objective: Day Case Laparoscopic Surgery (DCLS) is becoming an increasingly popular way of treating patients due to its cost effectiveness and secured outcome. However, its feasibility in treating endometriosis on outpatient basis is still debateable.
Aims and Methods: To investigate this, we studied retrospectively 50 patients who underwent laparoscopic surgery for endometriosis both as day cases or in-patients from March 2004 to August 2004. They were divided into Group A; (Day cases; no=12) and Group B (inpatients; no= 33) and compared with regard to demographics and perioperative outcome. Significance was accepted at $P<0.05$.
Results: There was no difference in the mean age of the patients for Group A 35.8 yrs (CI 33.2 -38.5), vs. Group B 34.6 yrs (CI 31.53 – 37.63; $P<0.05$). No differences were observed for the presenting symptoms between two groups (50% vs. 54.5% had <2 symptoms in Group A and B respectively). It was noted that previous surgery (laparoscopy/laparotomy) does not show any difference in ultimate outcome in both groups. There were no reported postoperative complications and there appears to be no difference in postoperative recovery for different types of procedures (excision, ablation, and adhesiolysis) in either group. Among Group B patients, those who stayed ≥2 days had laparoscopic surgery due to bowel involvement, dense adhesions and recurrent endometriosis. The total NHS cost for treating Group A patients was significantly less than Group B (£1,591.67 vs. £2,149.27 respectively; $p<0.01$).
Conclusion: This study demonstrated that DCLS for endometriosis is safe and cost-effective. It has potential benefits for the delivery of effective health care services and can replace inpatient laparoscopic endometriotic surgery by the use of appropriate better coordinated selection criteria, however further validation is required via multi-centre prospective randomised controlled studies.

P 047

The contribution of laparoscopy in the diagnosis of congenital uterine abnormalities

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Aim: Direct endoscopic visualization of pelvic cavity is nowadays widely used in the evaluation of congenital gynecologic problems. It is supported that the accuracy of the method is high in diagnosing uterine abnormalities.
Materials and Method: We report three such cases. In the first two cases there were a 19 and a 21 year old women, who both presented primary amenorrhea. In the third case, there was a 14 year old girl with normal menstruation and chronic pelvic pain. In all three cases the hormone evaluation revealed normal ovarian function, physical examination confirmed normal development of secondary sexual characteristics, with the presents normal vagina, the karyotyp was normal, (46XX) and the urinary system was normal as well. When examined with ultrasound, internal genitalia without a uterus were found in the first two cases, and a double uterus in the

14year old girl. Results:Laparoscopy revealed agenesis of uterus in the two cases, and uterus with a rudimentary left horn in the 14 year old girl. In all cases there were normal ovaries but the left fallopian tube in the third case was distended and filled with chocolate-like fluid, and it was immediately excised. Six months later, we plan to remove the rudimentary uterus horn.
Conclusion:Thus, laparoscopy presents high diagnostic value in the diagnosis of congenital uterus abnormalities.

P 048

The use of the hydrogynecograph in the evaluation of infertile women and the use of the fallopian tube catheterisation for tubal obstruction

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Aim: To determine the experience with these methods in evaluation and treatment of infertility
Materials and methods: 178 women were evaluatet for infertility with ultrasound.In 43 there were suggested abnormalities which were further evaluated with hydrogynecography. We indendified Polyps,adhesions,fibroids and tubal obstruction. Hysteroscopy was performed in 153 women and all 43 who had hydrogynecography.
Results: The agreement was very high

	Hysteroscopy	Hysteroscopy
Hydrogynecology	+	-
+	92	8
-	2	98

Tubal catheterization was done in 8 patients to open the tubes with 75% success.
Conclusion: The hydrogynecography and tubal cathetirisation are highly successfull methods and can be used even instead of hysteroscopy.

P 049

Laparoscopic treatment in postmenopausal women with adnexal masses

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Objetive: To evaluate the morbility and feasibility of laparoscopic treatment in postmenopausal women.
Design and Methods: We realized a retrospective and descriptive study of 105 patiens between January 2002 to Dicember 2004. The 19,04%, (20 patiens) were menopausal at the surgery time. We clasificated group A(general) and B(menopausal) and analyzed different factors such as: age, parity, sonography, tumoral levels, bilateral cases,peroperative complications, surgical procedure, convalescence average, rate of laparotomy, pathologic findings.We compared all the patiens that had been operated by laparoscopy in our hospital with the postmenopausal women in the same time. We carry out stadistical study using SPSS computer.
Results: The mean age was 36,24 (A) and 57,45 for (B).The mean size was 61,42(A) and 68,10(B). The convalescence average 2,30(A) and 2,50(B) days. The nulliparity rate was 51,4% for A and 20% for B. The laparotomy reconversion rate was 15,2% for A and 15% for B. Intraoperative complications happened in 21,9%(A) and 20%(B). Postoperative complications rate was 13%(A) and 25%(B).There were 1 transfusion in A .The cystectomy was the most used in A (57,1%) and anexectomy in B(95%). There were 2 bordeline tumor in B. The mean histologic finding were endometriosis (29%) and cistoadenoma (27%) for A and 45% cistoadenomas in B.
Conclusions: the laparoscopy is a safe surgical method for the management of adnexal masses. It allows a minimal invasive surgery in the most of the patiens. It does not exit diferences for the management of menopausal patients.

P 050

Surgical approach for endometrial cancer in senium

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Objetive: To evaluate the feasibility of the different approaches for the treatment of the endometrial cancer in the elder.
Design and methods: A descriptive and retrospective study from January 1996 to December 2004 of 52 patients.We clasificated in 3 groups:vaginal,laparocopy and laparotomy. We analyzed different factors such as: age, body mass, previous surgery, tamoxifen treatment, type of surgery, peroperative complications, laparotomy rate, convalescence average, transfusion rate,FIGO stadio, histological study and recurrence and survival rates. SPSS 11.5 was used for statistical analysis.
Results: The mean age was 72,67 (65-88) and body mass index 34,26 (23,1-52). The 11,5% had previous abdominal surgery, 61,5% had endometrial risk factors and 3,8% received tamoxifen treatment. The surgical access was 11,5% (6) vaginal, 38,5% (20) laparoscopy and 50% (26) laparotomy. Lymphadenectomy was feasible in 71,2% of the laparotomy and in 100% of laparoscopy (laparotomy reconversion rate 0%). The intraoperative complications rate was 19,2% (vaginal 16,6%, lps 10%, lpm 26,9%) and the postoperative one 30,7% (vaginal 50%, lps 20%, lpm 34,6%), the mean average convalescence was 7, 04 (vaginal 5 days, lps 5,84, lpm 5,20), transfusion rate was11,5% (33,3%vaginal, 0%lps, 15,4%lpm), the mean number of nodes was 14,5 for lps and 7,16 for lpm, the survival rate was similar in the different approach of surgery.
Conclusions: The endometrial cancer can be treated by different ways.Only the laparoscopy and laparotomy allow staging according to FIGO. The laparoscopy approach is a feasible technique with a short rate of peroperative complications and similar survival rate.

P 051

A combined medical – hysteroscopic conservative treatment of a viable cervical pregnancy: a case report

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Cervical pregnancy (CP) is an uncommon ectopic pregnancy that accounts for <1% of extrauterine gestations. This case report describes a case of CP successfully treated with systemic MTX therapy combined with hysteroscopic endocervical resection of the gestational sac.
A 38 years hold women, with a viable ectopic CP at a gestational age of 6 weeks received IM injection of 50 mg/die of MTX every other day for four days, with folinic acid rescue. After one week of interval, MTX treatment was repeated with the same administrations. At 9 weeks of gestational age ultrasonography revealed a dead fetus and a regressing gestational sac. Declining serum hCG levels was observed after the second cycle of MTX treatment, then

the patient underwent to the hysteroscopic resection of the ectopic CP. A 5 french hysteroscope (Karl Storz, Tuttlingen, Germany) was introduced into the cervical canal. The gestational sac was recognized and the implantation side as the extent of placentation was determined. A 5 french bipolar electrode (Versa Point, Gynecare, NJ, USA) was introduced through the operative channel of the hysteroscope and, under trans abdominal U/S guidance an electroexcison of the ectopic pregnancy at a cautery setting of 50 W was performed. Treatment was successful, the operating time was 35 minutes, the blood loss was 60 ml. The patient had an uncomplicated post operative course. This case report showed that a viable ectopic CP can be treated successfully with an appropriate systemic MTX regimen combined with a conservative hysteroscopic resection of the ectopic gestational sac

P 052

Visualization of ovulation process during transvaginal hydrolaparoscopy

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Technique of transvaginal hydrolaparoscopy allows minimally invasive exploration of the reproductive organs. The advantage of transvaginal hydrolaparoscopy is hydroflotation regimen allowing to inspect reproductive organs in physiologic conditions as well as to visualize the process of human ovulation. There was several sugesstions about the course of ovulation process. Nowdays, owing to transvaginal hydrolaparoscopy factual information is being collected.
Transvaginal hydrolaparoscopy was routinly performed for the investigation of infertile women. We observed periovulatory follicle in 20 women. Our findings show that ovulation may proceed by two different "scenarios"- avalanche–like evacuation of follicle and slow leakage of follicular fluid. In our observations fimbriae were not always involved in releasing of oocyte-cumulus complexes. Clinical significance of this data should be clarified.

P 053

Epidemiology of large cystic uterine adenomyomas

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Aim of the study: To study the incidence, epidemiology, and clinical presentation of large cystic adenomyomas (>3cm), in a University hospital population.
Patients and Methods: We performed a computer search in the Pathology Department of our Institution, spanning the period from January 1999 to December 2004, and were able to identify 26 cases corresponding to the diagnosis of a uterine cyst, or a uterine tumor with a measured cystic component. By reviewing the pathology reports we excluded all cases with cystic degeneration of a fibroid, and those with a non-adenomyotic cyst and were left with only 4 cases with cystic adenomyomas measuring >3cm and reviewed their case histories.
Results: Two patients presented with large cystic unilocular swellings that were erroneously diagnosed as paraovarian cysts and were proved at laparoscopy to be cystic adenomyomas attached to the uterus via a narrow pedicle. The 3rd case was also an adenomyoma originating through a broad base from the uterine fundus. The last case was a 5cm cystic submucosal ademomyoma presenting with irregular vaginal bleeding and protruding through the cervix. The former three cases were operated laparoscopically, whereas the later was managed with a TAH and BSO.
Conclusion: Large cystic adenomyomas are rare, and most commonly asymptomatic. Frequently they are erroneously diagnosed as adnexal enlargements and their true origin becomes evident during surgery. The differential diagnosis includes cystic degeneration of a fibroid and congenital uterine cysts from mesonephric or paramesonephric remnants.

P 054

Successful hysteroresectoscopy of a fundal myoma

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Hysteroscopic myomectomy is an excellent surgery for submucous myoma patients suffering from menorrhagia and/or infertility. A sessile myoma arising from the uterine fundus, however, is technically difficult to correct by standard hysteroscopic resection. A hysteroresectoscopic electrode, which moves only in a linear motion, is unsuitable for the resection of a large, sessile, face-to-face myoma, as its use risks an unexpected perforation to the fundus while digging into the node of the myoma.
We present herein a successful fundal myoma resection using a novel strategy. The patient was a 43-year-old nulliparous woman who had suffered from severe menorrhagia for several years. She exhibited a fundal submucous myoma that measured approximately 40 mm in diameter and was categorized as type II using the classification guidelines of the European Society for Gynecological Endoscopy. We performed a hysteroresectoscopy with concomitant laparoscopy, beginning by scraping the dome of the circumferential myoma with an electrode with a safeguard attached at its far end. Next, the central area of the node was vaporized to a flat surface using another electrode. Repeated resections were performed on the remnant node, squeezed by uterine contractions after the intraoperative injection of prostaglandin F2 alpha. Complete resection of the myoma was accomplished and her symptoms disappeared. Our combination of techniques – the use of monopolar electrodes and extruding the remnant myoma by oxytocic agent-induced uterine contractions – allows the safe and certain hysteroresectoscopy of a sessile submucous myoma arising from the uterine fundus.

P 055

Fertility outcome after laparoscopic myomectomy

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We conducted a retrospective study from November 2000 untill November 2004 to evaluate the fertility outcome after laparoscopic myomectomy. Twenty seven consecutive patients were admitted to this study with a mean age of 36.67±5.42 years and a mean diameter of myoma of 5.28±2.21 cm on sonography. Myomas were intramural in all patients with extension to the uterine cavity in twelve patients. All women were investigated for other causes of female infertility, and male infertility was ruled out for every case, so no other etiology than myoma was retained for these patients. No pregnancy was permitted for six months post-operatively and an interval of the next six months was given for spontaneous conception. Six patients (24%) became pregnant during this period (with a result of four live births and two pregnancy losses). Two patients were lost. Because of the advanced age of patients who did not become pregnant after one year we decide to induce ovulation or use IVF (in vitro fertilization), so eleven (44%) had induction of ovulation (with a result of three live births, two losses of pregnancy and six patients could not achieve pregnancy) and eight (32%) had IVF (with a result of four live births, two losses of pregnancy and two patients

could not achieve pregnancy). Such as a total of six (24%) losses of pregnancy occurred during the first trimester, eight (32%) could not achieve pregnancy and eleven live births (44%) was obtained after a mean of 1.8±0.3 years from laparoscopic myomectomy.

P 056

Laparoscopic management of borderline ovarian tumours in women of reproductive age and preoperative diagnosis of benign adnexal masses

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Aim: To review the clinical features of women with borderline ovarian tumours and preoperative diagnosis indicative of benign adnexal masses, on whom minimal access surgery has been performed.
Materials and methods: Between October 1992 and December 2004, 2954 operative laparoscopies were performed in the Centre for Endoscopic Surgery DIAVALKANIKO Hospital, of which 655 for adnexal masses in women of reproductive age. In the preoperative work-up transvaginal ultrasound was always used. When ultrasonographic findings did not meet criteria for low risk of malignancy, tumour markers, colour doppler and NMR were applied. At laparoscopy, our protocol included macroscopic examination of the cyst contents before sending the specimen for cytology, copious lavage of the peritoneal cacity, suction of the cyst content in cases of large cysts, taking care to minimize spillage and examination of the interior of the cyst. Any solid component or papilla was biopsed and submitted for rapid frozen section.
Results: Of 655 adnexal masses treated by laparoscopy in this age group, 5 (0.76%) were found in the rapid frozen section to be ovarian tumours of borderline malignancy. The mean age of these patients was 22±8.3 (17-32), the mean diameter of the cysts was 5.7±4.1 (4-11cm). In 4 patients laparoscopic adnexectomy was performed. In one patient, in whom preoperative diagnosis of bilateral endometriotic cysts was made, rapid frozen section showed borderline malignancy of both ovaries. In this case ovarian cystectomy was performed and the patient underwent 2 IVF trials, the second of which successful. Three years later the patient underwent bilateral oophorectomy.

P 057

Hysteroscopy in the workup of female infertility

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Aim: To evaluate the role of diagnostic hysteroscopy in the investigation of female infertility.
Materials and methods: 1077 patients underwent diagnostic hysteroscopy in the Centre for Endoscopic Surgery DIAVALKANIKO Hospital from October 1992 until December 2004. Patients were divided into three groups: Group I, 665 patients, of which 470 were below 35 years old and 195 above. Group II, 412 patients (242 and 170 respectively) and Group III, consisted of 114 patients who had undergone at least 2 unsuccessful embryo-transfers in the course of IVF trials. Hysteroscopy was performed without anaesthesia with a 3.5 mm rigid hysteroscope using the vaginoscopic approach, except in cases in which hysteroscopy was combined with diagnostic laparoscopy.
Results: The results of the hysteroscopic findings in the three Groups are described and analyzed according to the findings of the hysterosalpingography (HSG) and the age of the patients. In Group III, 31 patients were found with abnormal findings in the cervix (27%) and 39 (34%) in the uterine cavity.
Conclusions: Diagnostic hysteroscopy consists an essential part of the basic infertility workup. It is indicated in all cases with abnormal HSG, in women aged above 35 years old and in patients with at least two unsuccessful replacements of good quality embryos.

P 058

Hysteroscopic laser ablation of the endometrium (HLAE) for menorrhagia in a university teaching hospital in the UK

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Retrospective clinical audit from 2001 to 2005, assessing the outcome of the use of laser for the treatment of menorrhagia in over 100 patients under experienced hands. This poster summarises the recent advances in the use of laser, the practical aspects of the procedure, pre-operative patient assessment and suitability for the procedure. Also it describes intra and post operative complications and measures the success rate at 3 to 6 months post procedure.

P 059

Embryoscopy and its potential

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Embryoscopy is the direct visualization of the embryo between 5 and 8 weeks gestation age.Fetoscopy is the direct visualization of the fetus after 8 weeks of gestation.Both are performed by insertion of a fiber optic scope, either transabdominally or transcervically, into the extracoelomic space when the procedure is done before 11 weeks, or inside the amniotic cavity when it is done after 11 weeks.Embryo-fetoscopy is likely to find applications in confirming and further clarifying our knowledge on embryonic development.
High resolution ultra-sonography is the most common established approach to the antenatal diagnosis of congenital abnormalities, during the first and second trimester.In situations, though, where there is a family high risk of recurrence of genetic disorders that project onto embryonic phenotype or when antenatal ultrasound screening is highly suggestive of a congenital anomaly, embryoscopy could serve as a conclusive verification tool. Embryoscopy in missed abortions provides invaluable information on the phenotype of the embryos and help us clarify the specific mechanisms leading to the observed developmental defects and death in-utero. Information obtained by embryoscopy can identify the risk of recurrence in future pregnancies.Further evolution of the endoscopic instruments and embryoscopic technique could give embryo-fetoscopy a potential for early gene and cell therapy as well as surgery in-utero. We present our preliminary experience employing trancervical embryoscopy.

P 060

Current surgeries performed in our scope for the treatment of uterine and vault prolapse

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1. INTRODUCTION and OBJECTIVES: Given the relatively recent appearance in the market of new devices for the correction of feminine genital prolapse, we have initiated the use of these devices in our hospital as therapeutic and preventive methods. We currently use PERIGEE for anterior prolapse, and for the posterior compartment, infraccocigeal vault suspensions (Apogee, Posterior-IVS and PelviLace). We tried to evaluate the different techniques.
2. MATERIAL and METHODS: Thirty six patients with pelvic floor defects have been treated, 18 with posterior defect or uterovaginal prolapse with predominance of posterior defect have been treated with several posterior suspension treatments. The remaining 18 patients with anterior defect or uterovaginal prolapse with predominance of anterior defect.
3. RESULTS:
3.1. Infraccocigeal Sacrocolpopexies: Surgical Time: 21,06 ± 4,09 minutes, surgical complications: 0, hospital stay: treatment for isolated vaginal vault 12-24 hours and combined with vaginal hysterectomy 36-48 hours. Post-operating complications: Gluteal Hematomas: 3 (16,7%). Revisions at 1 and 5 weeks, 3 and 6 months: 1st degree cystoceles in 2 cases (11,11%), induration of wall at 5 weeks in 1 case (5,55%).
3.2. Regarding the anterior Corrections with Perigee: Surgical time: 24,11 ± 4.24 minutes, surgical complications: none, hospital stay: For isolated anterior wall defect 12-24 horas and combined with vaginal histerectomy 36-48 hours Post-operatorive complications: none. Follow up: (at 1 and 5 weeks, 3 y 6 meses): none .
4. CONCLUSIONS: So far the results are very promising and they seem to be good techniques to solve defects of pelvic floor.

P 061

Actual perspectives of our experience in the female stress urinary incontinence treatment (SUI)

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OBJECTIVE: To compare the retropubic and transobturator techniques performed for the treatment of female stress urinary incontinence.
MATERIAL And METHOD: We compare the first 53 first retropubic surgeries with the 53 transobturator ones to gather therefore the same conditions as far as experience in the learning curve, we found:

	SPARC	MONARC
Surg. Time	17,58±4,31m.	11,98±2,66 m.
BladderInjurie	1	0
Hematomas	0	0
Hospital stay	0	0
Hosp stay(asoc)	2.35±1,30	2,15±1,07
Obstruction	2	0
Failures	0	1

RESULTS: Revisions: They have been performed with specific quality of life questionnaires. They are performed systematically at 5 weeks, 3, 6 and 12 months.
We found: Smaller surgical Time for the transobturator, equal Stay, when performed isolated, since the two are considered outpatient techniques not requiring hospitalization. Surgical complications: 1 bladder perforation for the retropubica and no surgical complications for the transobturator. Postoperating complications: 2 temporary Obstructions with the retropubic technique and none with a the transobturator. Failures at 12 months: none with retropubic technique and 1 with the transobturator. This was a technique failure demonstrated in the post-operative follow-up.
COMMENTS: In agreement with most of the published data, at the moment it seems that the transobturator technique has the same results as the retropubic technique, however the first one is simpler and has a shorter operating time.

P 062

Extrusion and vesicovaginal fistula after traditional anterior rectus sling

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CLINICAL CASE: 47 years old patient that shows up in July of 2001 for revision.
At the time of the check she complains of urinary incontinence with minimal efforts and mictional urgency. The urodinamic study, shows stable bladder and deficient uretral sphincter. A suburetral sling is performed in December of 2001. Later in February of 2002 she visits the Gynecologist complaining of a bulk in the external genitals. At time of exploration a IInd-IIIrd degree prolapse is observed.
The patient is still incontinent and she is treated with several anticolinergic drugs and rehabilitation exercises awaiting operation.
In January of 2003 is performed a vaginal histerectomy. The postoperative revision is normal except the area corresponding to the sling that is painful when palpating. The patient still complains of urge incontinence. In January of the 2005, we valued sling removal and I mention to evaluate the height of the sling in urethra placing a Foley catheter. With the Foley in place the vaginal exploration surprisingly finds the Foley catheter in vagina.
A cystoscopy is performed observing the sling in the vaginal area and a fistula above the sling. The sling removal is considered with the closure of the vesicovaginal fistula.
Conclusion: It is still to be determined the reason for the fistula: the correction of the stress urinary incontinence with sling and the vaginal hysterectomy.

P 063

Comparative study of complications between laparoscopic assisted vaginal hysterectomy and total laparoscopic hysterectomy

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Objective: Comparative study of the operative complications in the period 1996-2004 between laparoscopic assisted vaginal hysterectomies (LAVH) and total laparoscopic hysterectomies (TLH).
Material and Methods: 213 LAVH (Group I) and 230 TLH (Group II) were performed in the studied period. The indications in group I were 23 cases for endometrial adenocarcinoma (10,8%) and 190

cases for benign pathologies (89,2%). 52 patients in group II (22,6%) were operated for endometrial adenocarcinoma and 178 (77,4%) for non malignant pathology. A comparative study between both groups was performed in terms of intra and postoperative complications. A comparison is also performed between the periods 2000-2003 and 2004, after the introduction of modifications in the surgical technique.
Results: In Group I (LAVH) the complication rate was 12,2%, 21 cases of major complications (9,9%) and 5 cases of minor complications (2,3%). Major complications detected were: 13 blood transfusions, 6 bladder injuries, one recto-vaginal fistula and an intestinal occlusion due to bowel incarceration in a 12 mm port site. In group II (TLH) 17 complications were detected (7,4%), 11 major (4,8%) and 6 minor complications (2,6%). Major complications recognized in this group were: 8 blood transfusions, one vesicovaginal fistula, one bladder lesion and a case of spleen injury. Comparative studies between groups showed no differences in total complication rate (p:0,12), major complication rate (p:0,06) and minor complication rate (p:0,89). Comparison between periods of study showed a reduction in complication rate in 2004 (2,6%) in comparison to period 2000-2003 (9,9%) (p:0,03).

P 064

Reproductive outcome following auto-crosslinked hyaluronic acid gel application in infertile patients after laparoscopic myomectomy

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Objective: To assess the reproductive outcome after laparoscopic myomectomy and post-surgical adhesions prevention with auto-crosslinked HA gel. Design: Prospective, randomised, controlled study. Thirty-six infertile women underwent laparoscopic myomectomy. Eighteen were treated with HA gel for adhesions prevention (group A), 18 were untreated (group B). All patients underwent post-surgical adhesions evaluation and a reproductive outcome follow-up for 12 months.
Patients who did not conceive, after 6 month, underwent ultrasonographic monitoring of ovulation from 7th to 12th follow-up month. In this period 4 out of 10 patients of group A and 5 out of 14 of group B underwent controlled ovarian hyperstimulation. Results: At 1 year follow-up, pregnancies occurred in 77.8% of patients in group A and in 38.8% of cases in group B. In both groups, pregnancies were higher in patients treated with subserous sutures than in subjects treated with interrupted figure of eight sutures. No differences were noted between Cesarean section and vaginal delivery rates beetween groups.
Conclusions: Auto-crosslinked HA gel is useful to prevent post-surgical adhesions formation in infertile patients after laparoscopic myomectomy and it increase the pregnancy rate more than laparoscopic myomectomy alone

P 065

Prevention of adhesions with a cross-linked hyaluronan gel after laparoscopic myomectomy

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BACKGROUND: Association between postsurgical adhesions and bowel obstruction (55%), chronic pelvic pain (13-36%), and infertility, (15-20%) has been widely demonstrated. Adhesions prevention plays a basic role mainly in reproductive surgery and after adhesiolysis the pregnancy rate increases from 38 to 52%.
OBJECTIVE: The aim of this clinical prospective, randomized, study was to evaluate the efficacy of crosslinked hyaluronan gel in adhesions prevention after laparoscopic miomectomy, and to perform a histological analysis of adhesions.
METHODS: We studied 44 women in reproductive age, without previous surgery, who underwent to single or multiple miomectomy. 22 of these patients underwent laparoscopic miomectomy only, and 22 also to hyaluronic acid application. 30-60 days after surgery, all patients underwent to second-look with minilaparocromosalpingoscopy. The adhesions at the second-look laparoscopy were sent out for histological analysis. The specimen were stained with haematoxylin-eosin and the assessment was based on the absence (0/+) or presence (++/+++) of fibrosis, inflammation and vascularization.
RESULTS: Anatomically significative adhesions were found in 7 (31.8%) of the treated group and in 12 (54.5%) of the control group. The average site-specific modified score of adhesions was 1.05±1 in the sample group and 2.27±2.5 in the control group ($P<0.05$).
The histological analysis of adhesion tissues in the control group revealed a higher incidence of fields containing fibrosis, leukocytes and vessels than in the sample group ($P<0.01$).
CONCLUSIONS: Cross-linked hyaluronic acid appeared to be easy to handle, well-tolerated, biocompatible and effective. Adhesions found in treated group were mainly velar, avascularized and easily lysable, whereas those in control group were dense (thick) and strongly vascularized.

P 066

Transcervical metroplasty

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A technique of metroplasty is presented. Four patients had completely septated uterus, six incompletely, and four had arcuate uterus. All patients had repeated wastage or infertility. The uterine septum was diagnosed in every case by hysterography, ultrasonography, or diagnostic hysteroscopy. The septum has been cut with laparoscopic scissors (5 or 10 mm) introduced into the uterine cavity through the cervix. The operation was performed under general anesthesia. Whole procedure has been monitored with a real–time abdominal ultrasound. All patients had control hysteroscopy and complete unification of uterus was achieved. No significant intraoperative nor postopertive complications were noticed. The results of this technique of metroplasty are comparable with those obtained after hysteroscopic uterine septum resection. This procedure is simple, safe, efficient and does not require expensive endoscopic equipment.

P 067

Primary malignant mesothelioma of the peritoneum in a young woman with unexplained ascites

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Case report: We report the rare case of a 27 year-old, P 0+0 woman who was referred to our institution for persistent moderate ascites. One year before her present admission she underwent a diagnostic laparoscopy for the same indication. No obvious pathology was found, random biopsies showed only inflammation, and she was prescribed antibiotics for a presumed pelvic infection. During all this period despite persistence of the fluid collection she remained asymptomatic. Although preoperative CA-125 was moderately ele-

vated (320 U/ml), no obvious pathology was found at the preoperative diagnostic work-up. At second-look laparoscopy, a 2cm fragile soft tumor was found in the pouch of Douglas, and was excised. All peritoneal serosal surfaces were found with multiple widespread miliary deposits. Histology was suggestive of a primary malignant peritoneal mesothelioma. The patient received combination chemotherapy and remains disease-free 9 months from diagnosis.
Conclusion: Persistent ascites should be regarded with suspision until proven otherwise. Rare or occult tumors, infections, and systematic pathological conditions should be included in the differential diagnosis. Laparoscopy can be a very useful minimally invasive diagnostic tool and should be applied liberally whenever the diagnosis is doubtful.

P 068

Site specific pelvic floor repair

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Objective: Trial of a new technique to correct posterior vaginal wall prolapse using synthetic mesh.
DESIGN: A prospective study.
MATERIAL&METHODS: Forty seven patients complaining of different types of posterior vaginal wall prolapse were collected from the outpatient clinic of EL SHATBY maternity university hospital and other private clinics. All cases were treated by the same technique by the same surgeon .In all cases a prolene mesh was fixed in the rectovaginal space by absorbable sutures.
Results: Dissection of the rectovaginal space was done as usual but to higher levels to fix the mesh, and it was an easy task. The range of operation time was 20-45 min. No patients complained of vaginal tightness or dyspareunia postoperatively. One case had partial erosion of the mesh that was treated conservatively. Twenty two cases complained of perineal heaviness postoperatively that disappeared spontaneously after a maximum period of 3 months. Forty two cases seemed satisfied with the technique, and five cases were unsatisfied.
Conclusions: It was evident from this pilot study that the technique is easily adoptable, easily transferable to trainees, consumes reasonable time and has a relatively low rate of complications, but longer postoperative follow up time being a new technique.

P 069

Laparoscopic management of ovarian mature cystic teratomas

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SETTING: OB/GYNE DEPT, Alexandria University
PATIENTS: 40 cases with mature cystic teratomas selected from the outpatient clinic of El-Shatby University hospital
All patients are between 18-40 years, with unilateral or bilateral dermoid cyst not exceeding 10 cm diameter.
Those patients with criteria suggesting malignancy(by u/s or laparoscopy) were excluded
METHODS: History taking, clinical examination, high resolution vaginal ultrasound, CA 125.
Intervention: Laparoscopic excision of the mature cystic teratoma through incision in the anti -mesenteric border of the ovary with hydrostatic dissection. The ovary left without suturing. Excessive lavage using 10 litres of normal saline were done in those cases with spillage.
RESULTS: Laparoscopic resection were done in all patients. None was transformed into laparotomy. Mean operative time was (70min). Mean blood loss (40 ml). Post operative fever (16%). Peritoneal spillage (80%). Duration of hospital stay (1day). Bilaterality of the tumour (12%). Chronic post operative pelvic pain (none). Chemical peritonitis (none).
Conclusions: Laparoscopic resection of benign cystic teratoma is safe procedure and in presence of good preoperative preparation it must be the rule with exception only extensive pelvic adhesions and malignant suspicions.
Advantages over laparotomy were diminished blood loss, hospital stay, postoperative fever, postoperative treatment.
Although spillage had occurred in most of the cases none of them developed chemical peritonitis.

P 070

Endometrial cancer: minimal invasive surgery but maximal effective therapy

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Introduction: Surgery is the primary therapy of endometrial cancer. As endometrial cancer occurs more frequently in elderly and fatty patients, the minimal-invasive surgery seems to be the optimal way to treat the disease. The objective of our study was to evaluate the feasibility of laparoscopic surgery in the treatment of the endometrial cancer.
Patients and methods: Retrospective analysis of all endometrial cancer patients who were treated by laparoscopy between 1996 and 2005 in three different hospitals (Berne, Lugano and Schaffhausen). All patients underwent a total laparoscopic hysterectomy with bilateral salpingo-oophorectomy and, if necessary, a laparoscopic pelvic lymphadenectomy followed or not by a paraaortic lymph node dissection. The patients were followed after 3 and 6 months, and then every 6 months.
Results: A total of 103 patients were included in the study. The median age was 65.1 (47-88) years. 87 (84%) patients had an endometrial cancer FIGO stage I, 8 (8%) a FIGO stage II, 6 (6%) a FIGO III and two (2%) a FIGO stage IV. The median operating time was 160 minutes. Estimated intraoperative bloodloss was 230 ml. 94 patients (91%) underwent a laparoscopic lymph node dissection. The average number of lymph nodes recovered was 22.7. The median hospital stay after the operation was 5.7 days. After an observation time of 2.6 years 98 (95%) patients were without signs of recurrence. In our collective no port-site metastasis were found.
Conclusions: With the appropriate experience in endoscopic surgery, endometrial cancer can be treated by laparoscopy. The operation time as well as the number of recovered lymphnodes is comparable with the historical published results obtained by laparotomy.

P 071

Evaluation of abnormal uterine bleeding by transvaginal 3-D sonography

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Aim: The aim of our study was to identify the role of 3-D sonohysterography (HS) in women with abnormal uterine bleeding.
Materials-Methods: A total of 56 women between 29 and 64 years old were included in the study. All of them presented abnormal uterine bleeding and they gave verbal consent prior to the procedure. After a transvaginal ultrasound, a saline 3-D sonohysterography was performed in all cases. Following this, all women were referred for dilation and curettage and histolpathological results were compared to the sonographic findings.

Results: The 3-D sonohysterography procedure was well tolerated with no significant complication. In 18 cases an endometrial polyp was found (32,1%), in 7 cases a submucosal leiomyoma (12.4%), in 9 cases an endometrial hyperplasia (16%), in 1 case a foreign body (IUD) (1,7%), in 4 cases an endometrial cancer (7,1%) and in 18 cases was found normal endometrium (32,1%). The sensitivity of transvaginal 3-D sonohysterography was 100%.
Conclusion: Sonohysterography performed with 3-D ultrasound has several advantages than conventional 2-D ultrasound. 3-D(HS) defines better the pathology of uterine cavity and gives more accurate information concerving the location of abnormalities.

P 072

Diagnostic hysteroscopy in women with abnormal uterine bleeding receiving hormone replacement therapy

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Objective: to investigate the causes of abnormal uterine bleeding (AUB) in perimenopausal period in women receiving hormone replacement therapy (HRT) or presenting postmenopausal bleeding and to evaluate the efficacy of hysteroscopy in the diagnosis of endometrial pathology. These patients referred to our academic gynaecological clinic during the period (1999-2003).
Materials and Methods: a retrospective review of 145 cases that had undergone hysteroscopy and endometrial biopsy for AUB during perimenopausal period in the last four years. The main group (76 patients) presented AUB during taking sequential or continuous HRT for menopausal symptoms and prevention of osteoporosis. The control group (69 patients) presented postmenopausal bleeding.
Results: There was an increased incidence of endometrial pathology in the group receiving HRT in comparison with the control group (52,6% versus 40,4%) but this difference was not significant. The main findings are functional endometrium (38,1%) in the group receiving HRT and atrophic endometrium (40,6%) in the control group respectively. These differences were statistical significant between the two groups. Diagnostic hysteroscopy was performed successfully with no serious complications and was performed without anesthesia in a percentage over 30% of the patients in both groups.
Conclusions: The incidence of the structural endometrial causes of AUB in perimenopausal period are similar in women taking HRT or presenting postmenopausal bleeding. Hysteroscopy is a safe and efficient method of investigation of women with AUB in the perimenopausal period. In addition, the increasing use of outpatient hysteroscopy will simplify the way of assessing patients presenting with AUB in the perimenopausal period.

P 073

Type of anaesthesia and telescope diameter: two important factors affecting patient's compliance in outpatient hysteroscopy

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Objective: A retrospective study evaluating the type of analgesia and the importance of telescope diameter in outpatient diagnostic hysteroscopy as well as the safety and acceptability of this method in the investigation of the uterine cavity. Materials and Methods: An analysis of 247 outpatient diagnostic hysteroscopies that were performed for the investigation of women with abnormal uterine bleeding (AUB), abnormal ultrasound findings and infertility. The patients were referred to our department, in the period (2001-2004). The procedures were performed with two types of hysteroscopes with fore oblique lenses of 4mm and 2,7mm diameter, respectively. 138 patients included in the first group (4mm telescope) and 109 patients included in the second group (2,7 mm telescope). Results: Outpatient diagnostic hysteroscopy was performed successfully with no complications and no anesthesia in 81,8% of the total number of patients. Local analgesia and cervical dilatation were performed in 18,2% and 6,9% of all patients, respectively. Compliance to the procedure was better in women who underwent hysteroscopy using the smaller diameter telescope (they required local analgesia and cervical dilatation in 24,6% and 10,8% versus 10,1% and 1,8% percentage of the first group patients, p=0,0055, p=0,0038). Conclusions: Outpatient hysteroscopy is a safe and effective method in the investigation of endometrial cavity. It can be performed without analgesia in most cases or local anaesthesia alternatively. The feasibility of this procedure is affected by the telescope diameter and the experience of the operator.

P 074

Operative laparoscopy in the management of benign adnexal cysts: is it a safe approach?

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The aim of this study was to evaluate the laparoscopic approach to benign adnexal masses in 211 premenopausal patients selected with strict preoperative clinical and ultrasound diagnosed criteria.
Operative laparoscopy was successfully managed most patients (98,2%). Four patients underwent a laparotomy (1,8%). The rate for the unexpected adnexal malignancy in this study was 0,48%.
As a conclusion, we consider that operative laparoscopy is a safe and effective procedure for the treatment of most benign adnexal masses in premenopausal women. In order to reduce the possibility of encountering an unexpected malignancy when approaching an adnexal cyst by laparoscopy, appropriate preoperative selection of patient candidates for laparoscopic treatment is mandatory. If an unexpected malignancy arises during laparoscopy, a team with specific oncologic training should be available for a possible immediate staging laparotomy in order not to affect the patient's prognosis.

P 075

Hysteroscopic treatment of abnormal and dysfunctional uterine bleeding

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The objective of this retrospective study is to evaluate the safety, efficacy and benefits of hysteroscopic surgery in the management of intrauterine lesions causing menstrual disorders in premenopausal women. There were also evaluated the results of the transcervical resection of the endometrium (TCRE) in cases of menorrhagia or dysfunctional uterine bleeding (DUB). Material and Methods: Operative hysteroscopy in 255 patients with abnormal uterine bleeding due to intrauterine pathology (endometrial polyps, submucous myomas, endometrial adhesions) diagnosed by transvaginal ultrasound or diagnostic hysteroscopy. Also, in the study population were included 27 patients (10,5%) who presented dysfunctional uterine bleeding and menorrhagia resistable to medical therapy that underwent TCRE. Results: Operative hysteroscopy was a successfull procedure in 98,8% of the cases but it was repeated in 3 cases with

large submucous myomas of type I and II. During postoperative follow-up period (12-36 months) the majority of patients (96% or 245 patients) were free of symptoms. The mean duration of the procedure was 32,1 minutes (range 4-58 min) and mean postoperative hospital stay was 0,5 days (0-2 days). There were two cases with fluid overload and five with postoperative uterine bleeding.
Conclusion: Hysteroscopic surgery is an effective and safe method for the management of the benign intracavitary pathology or the treatment of dysfunctional uterine bleeding. In addition, it has the advantages of quick recovery, early return to work and reduced hospital stay for the patient. It avoids the use of major and unnecessary surgery in many cases and improves clinical symptoms and iron deficiency anemia.

P 076

Preliminary clinical evaluation of patients with stress urinary incontinence treated with a vaginal sling-operation

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The analysis involved 60 patients with confirmed SUI who underwent TOT surgery at our Hospital in 2004. The average age was 60,5 years (33-84). The incontinence complaints duration was in the 5–20 years range. The mean BMI was 27 kg/m2 (19–40 kg/m2). 50% of patients had arterial hypertension, 18% had coronary disease, 5% had asthma, 8% had diabetes, 11 % reported vertebral degenerations, four patients presented thyroid hyperactivity, 2 patients were treated for depression. 40% of patients went through 2 labours, 17 patients had >2 labours, one patient was nullipara, 12% had one labour, 2 patients underwent forceps deliveries, one patient underwent caesarean section and one went through labour and caesarean section. HRT was administered to 13% of patients, 15% reported smoking. 28 were subject to TOT surgery alone; another 32 patients underwent TOT with pelvic floor corrective surgery. The average surgery duration for SUI alone was 21 minutes, with average blood loss of 64 ml. No patient suffered intra-operative complications. In early post-operative observation, one patient reported temporary continence problems; in 2 patients (3,33%), micturition problems were observed, requiring bladder catheterisation. In a 6-month observation, 51 patients (85%) were considered cured, 6 patients (10%) reported urgency without SUI evidence , 1 patient reported improvement in effort continence, 2 patients (1,6%) did not notice improvement.
In preliminary clinical evaluation, TOT seems to be an effective and safe method for surgical treatment of SUI.
The final effectiveness of the procedure will be assessed after a few years' observation.

P 077

Antimicrobial prophylaxis in laparoscopic gynecologic surgery: first Russian pharmacoepidemiological survey

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Background. Numerous studies have been published in recent years about the efficacy of antimicrobial prophylaxis in gynecologic surgery, but there are limited data about using of antimicrobials as a prophylaxis for laparoscopic surgery in Russia.
The aim. Our survey was designed to record the use of antibiotics and the policy of prescription of antimicrobial drugs as a prophylaxis for laparoscopic gynecology surgery.
Methods. We conducted multicenter retrospective pharmacoepidemiological study based in 7 centers (Moscow, Smolensk, Vladivostok, Petropavlovsk, Jakutsk, Tjumen, Krasnodar). During first phase of the study the date from 450 cases were analyzed. The data were taking from obstetrics and gynecology clinics in 2003-04 years.
Results. As a perioperative prophylaxis antimicrobials were used in 88% cases but in all patients antibiotics were administrated after surgery. Most often (37,5% of all prescriptions) were prescribed cephalosporins – cefuroxime, cefazolone, cefotaxime. Other beta-lactams antibiotics - ampicillin and amoxicillin/clavulanat had the same prescription frequency -12,5%. Other antibiotics – such as aminoglycosides, combined beta-lactams (oxacillin/ampicillin) were used less then 10% cases.
Conclusions. Antimicrobial prophylaxis in laparoscopic gynecologic surgery in Russia was used often but inappropriate. The most often mistake was administration of the antimicrobials after surgery. The most often prescribed antimicrobials for prophylaxis in laparoscopic gynecologic surgery were cephalosporins.

P 078

Laparoscopic management of unicornuate uterus with non-communicating rudimentary horn

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INTRODUCTION: Unicornuate uterus with rudimentary horn is a rare congenital anomaly, which occurs due to partial development of one of the Mullerian ducts during the 8tn week of intrauterine development.
MATERIAL AND METHODS: We describe the laparoscopic management of unicornuate uterus with a non-communicating rudimentary horn in two nulliparous women (28 and 24 years old) who presented with lower abdominal pain and dysmenorrhea. After preoperative assessment laparoscopy revealed unicornuate uterus with non communicating rudimentary horn. The rudimentary horn was attached to the uterus with a band of tissue. Both patients were managed with laparoscopic removal of the rudimentary horn along with the ipsilateral salpinx.
The excised specimen was removed through the extended suprapubic port site. No complications were reported intraoperatively. The patients were discharged home the following day and remain asymptomatic ever since.
CONCLUSION: Mullerian anomalies can be managed endoscopically. After careful preoperative evaluation and exclusion of coexisting anomalies of the urinary tract, the laparoscopic removal of a non-communicating rudimentary horn Should be the treatment of choice.

P 079

Significance of hysteroscopy in the detection and removal of small endometrial polyps in infertile women with normal menstruation

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Aim: To determine if the incidence of small endometrial polyps detected hysteroscopically in an infertile population differed from that in an apparently fertile population as well as to assess whether removal of such lesions would enhance reproductive outcome.
Methods: In a retrospective study, 166 permanently infertile women had undergone complete fertility evaluation.
All patients were examined by combined laparoscopy and hysteroscopy. In all patients laparoscopy did not reveal any pathology and the only pathologic finding during hysteroscopy was endome-

trial polyps. They were divided into two groups: 136 infertile patients (group 1) and 30 requesting a reversal of a previous tubal sterilization (group 2). The fertility-related factors, in all women . Patients were followed up to determine their reproductive outcome subsequent to removal of the polyps.
RESULTS: 127 uterine cavities were successfully visualized in group 1 and 29 in group 2. Endometrial polyps were noted in 45 patients of group 1 (40%) and in 3 patients of group 2 (10%) (P<0.01). A 50% pregnancy rate was achieved in the first semester after hysteroscopic polypectomy.
Conclusion: Endometrial polyps, even if small, were likely to impair fertility in this selected patient group. Thus, removal of such lesions may improve reproductive outcome.

P 080

Surgical treatment of ectopic pregnancy: moving from laparotomy to laparoscopy

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Study aim: To evaluate the occurrence, mode of treatment and fertility outcome of ectopic pregnancies in our hospital over an eight year period (1999-2004).
Material and Methods: 70 patients were treated in the Department from 1999 to 2004, their medical records were reviewed. Patients were divided in two groups, G1 and G2. We encountered 72 tubal, 4 corneal, 2 ovarian and 2 heterotopic pregnancies. Surgical treatment included salpingectomy or salpingostomy, by laparoscopy or laparotomy, medical treatment was by administration of methotrexate.
Results: During the first study period (1999-2000) the majority of cases was treated by laparotomy 22/29 (73.9%), 4/29 (13.7%) were treated laparoscopicaly and 3/29 (10.3%) with methotrexate . During the second period (2001-2004) laparoscopic treatment gained ground over open surgery, 46.4% patients had open laparotomy and 29.3% laparoscopy (double compared to G1) and 24.3% methotrexate.
Discussion: Minimally invasive surgery is well established in the treatment of ectopic pregnancy among a wide variety of other gynaecological conditions. Efforts are made to organise the Gynaecological Endoscopy Unit in our Department and offer minimally invasive approach to a wide range of gynaecological pathology, when it is indicated.

P 081

Laparoscopic treatment of idiopathic hemoperitoneum: a clinical case report and review of the literature

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Introduction: Spontaneous Hemoperitoneum is a rare occurrence usually presenting as diffuse abdominal pain and signs of cardiovascular compromise.
In women, common causes are trauma, ectopic pregnancy, rupture of ovarian cyst, malignancies of the reproductive or gastrointestinal tract and ruptured aortic aneurysm. We describe a case of idiopathic hemoperitoneum and review the literature.
Methods: We describe a case and the results of a literature search for idiopathic hemoperitoneum using the words idiopathic, spontaneous, hemoperitoneum, intraabdominal, bleeding, hemorrhage.
Results: A 32 year-old woman, presented with spontaneous hemoperitoneum. After 1,200 ml of fresh blood were evacuated laparoscopically, a thorough examination did not reveal a source of bleeding. A meticulous laparoscopic exploration of the entire abdomen failed to reveal the etiology. The patient was discharged home the following day without administration of blood products. Her follow-up visits up to 24 weeks were unremarkable.
Forty-seven cases of spontaneous hemoperitoneum in women have been described in the literature, including 22 cases of ruptured hepatocarcinomas, five ovarian pregnancies, four aneurysms of the gastrointestinal tract, three ruptured uterine vessels, one case of a uterine rupture due to placenta accreta, and a case of a ruptured spleen. These cases were managed through exploratory laparotomy. We found no reported cases of idiopathic hemoperitoneum.
Conclusions: Spontaneous hemoperitoneum is a rare occurrence. We describe a case of idiopathic hemoperitoneum that was treated successfully laparoscopically by a team of a gynecologist and a surgeon. We also discussed the common causes of spontaneous hemoperitoneum.

P 082

Successful in vitro fertilization after laparoscopy in a patient with retroperitoneal fibrosis

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Background: Retroperitoneal fibrosis (RPF) is characterized by the replacement of the normal tissue of the retroperitoneum with fibrotic tissue.
Objective: We wished to treat a patient with RPF for infertility.
Patient: A 34-year-old woman with corticosteroid controlled RPF and a six year history of infertility wished to become pregnant. The patient had undergone two abdominal surgical procedures for hydronephrosis and ileus.
Intervention: Examination was undertaken to determine the cause of the patient's infertility. Hydrosalpinx of the right fallopian tube was found as well as pooling of contrast medium in the left tube following hysterosalpingography. Laparscopy was performed to estimate the pelvic cavity volume, and adhesions were found surrounding the adnexa bilaterally. No impediments to pregnancy were found, and we proceeded with IVF. As anti-estrogen therapy is effective for the treatment of RPF, we carefully observed the relationship of high plasma estradiol concentrations during human menopausal gonadotropin (HMG) induction and pregnancy with changes in the RPF condition.
Results: The patient's RPF was not worsened by HMG induction, and the patient became pregnant after the first IVF trial. During pregnancy, mild right hydronephrosis developed at 24 weeks of gestation; premature delivery occurred at 34 weeks of gestation. No changes in the patient's RPF was seen throughout the pregnancy.
Conclusion: High plasma estradiol concentrations associated with pregnancy did not aggravate RPF symptoms in this patient. In cases of RPF, laparoscopy may be useful in determining the appropriateness of IVF.

P 083

The influence of the partial septated uterus on the reproductive outcome in a general population

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Several retrospective observational studies show that uterine septa have bad reproductive outcome with an increased incidence of early abortions and premature deliveries. In those studies mostly women with a difficult reproductive history were studied. We were interested in the incidence of uterine septa (AFS 5 and 6) and its connection to spontaneous abortion and premature delivery in a population of women who had hysteroscopic evaluation of the

uterine cavity due to other reason than reproductive health problems. 529 women (53.4±11.9 years) visited our outpatient hysteroscopy (HSC) office because of bleeding disorders, ultrasonographically suspected endometrial pathology or because of missed IUD. In all of them a HSC was performed. In 15.9% we found a septate uterus. 14.4% of all women reported spontaneus abortion and 8.9% premature delivery. The number of spontaneous abortions was higher in the group with septate uterus compared to the other group (0.5±0.8 vs 0.1±0.8, p<0.0001), the abortion rate was 36.4% to 8.9% respectively (p=0.024). The number of preterm deliveries was higher in the group with septete uterus as well (0.29±0.6 vs 0.1±0.2, p=0.0001), the preterm delivery rate was 11.7% to 1.7% respectively (p<0.001). There were no differences regarding age and number of deliveries between both groups. None of the patients was treated for infertility. Our analysis shows that septate uterus increases the risk of spontaneous abortion and preterm delivery. We think that further prospective studies are needed to elucidate this data.

P 084

Office hysteroscopy and laser-ozone-no techniques in infertile women

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Objectives: To develop the program for diagnosis and treatment of infertiled females with uterine disorders.
Design and methods: 320 women with infertility had undergone office hysteroscopy. 140 patients were in IVF program. Intrauterine abnormalities were determined in 278 (87%). Immunohystochemical research showed estrodiol and progesterone receptors dysfunction in 53% patients. High power laser was used to irradicate hyperplasia, polips, adhesions, myomas. Ozone and NO were used to improve receptors activity
Results: Pregnancy rate witin 1 year in IVF groups was 43%, spontaneous pregnancies were obtained in 63% of patients.
Conclusion: office hysteroscopy with laser, ozone and NO afters the possibility of diagnosis and treatment intrauterine disorderes and infertility.

Late Poster

P 085

Left side predominance of ovarian endometriomas

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Background: Laterality of endometriomas have not been investigated properly.
Objective: To investigate the left- and right-sided distribution of ovarian endometriomas
Materials & Methods: We retrospectively evaluated women who underwent laparoscopic surgery for the ovarian endometriomas. Data were collected from the operative records and operating room database of department. Patients age, parity, indication of laparoscopy, localization and diameter of endometriomas, presence of endometriotic implants and adhesions, preoperative and postoperative CA-125 levels were the variables extracted from the database.
Results: During the period investigated in this study, 178 women underwent laparoscopic surgery for the ovarian endometrioma. Of the 178 patients, 22 (12.3%) were excluded from the analysis because of insufficient data therefore total 156 patients were evaluated. Mean age of the patients was 32 (range 22-53). In 48.1% of the patients endometrioma was found on the left, whereas in 33.3 % on the right side. This left side predilection was statistically significant (p<0.001). On the other hand, 18.6% of the cases were bilateral. Occurrence of major or minor adhesions and endometriotic implants was not related with diameter or localization of endometriomas (p> 0.05). There was a positive correlation between the size of endometriomas and preoperative CA-125 levels (p<0.01). Postoperative CA-125 levels revealed a statistically significant decrease when compared with preoperative levels (p<0.001).
Conclusion: Endometriomas are found on the left side predominantly. Further studies are needed to evaluate for the clinical importance and the etiology of this entity.

P 086

Transobturator tape procedure with concomitant pelvic organ prolapse surgery

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Initial reports of transobturator technique suggest that it may have a similar efficacy to TVT but with a lower rate of serious complications.
OBJECTIVES: We report the efficacy and feasibility of concomitant pelvic reconstructive surgery with transobturator tape (TOT) procedure to treat pelvic organ prolapse of women with urinary stress incontinence(USI).
METHODS: Twenty two consecutive patients with stress urinary incontinence underwent the transobturator tape procedure. Preoperative evaluations included: complete history and physical examination, urinalysis, urodynamic investigations, abdominal and pelvic ultrasound. Quality of life assessment was carried out pre- and postoperatively. All patients with urinary stress incontinence underwent (TOT) treatment under general anesthesia, combined with transvaginal hysterectomy (VH), anterior-posterior colporrhaphy (APC). A cotton-swab test was performed before the procedure and at the 12-week postoperative follow-up visit to evaluate proximal urethral mobility. Cure was defined as the absence of leak during cough stress testing at cystometric capacity.
RESULTS: Mean operative time was 54 (31-96) minutes. No major intraoperative complications were observed. Mean age was 56 (39-79) years. All patients were examined at 3 months from intervention. The cure rate for the treatment of urine incontinence was 94%, and the objective complete success rate was 96%.
CONCLUSION: Women with urinary stress incontinence and pelvic organ prolapse can be treated by transobturator tape procedure combined with reconstructive surgeries.

V 001

Hysteroscopic polypectomy in private practice

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We have been practicing operative hysteroscopical procedures in Athens since 1993, as hysteroscopy was an interesting procedure for our infertility clinical practice. We have done more than 400 procedures during these years for women aged 22y-74yrs that refer mainly to polypectomy, and less to myomectomy.
The polypectomies were done under anaesthesia with propofol with the duration of the surgery usually limited up to 10 minutes. The decision for the procedure was undertaken by previous ultrasonography. Polypectomy, even when more than one polyps are present in the uterine cavity, is a safe and quick procedure because it involves no severe hemorrhage, and uterine perforation is difficult to occur. We are using purisol (sorditol 27gr/lt plus mannitol 5.4 gr/lt) as distention media and Hamou endomat (Storz, Karl Storz endoscope) and resectoscope with external sheath of 9.5 mm as main equipment. In rare cases of presence of polyps with myomas that protruded in the uterine cavity repeated interventions need to be done (up to three, in a case of congenital malformation of the uterus with previous abdominal reconstructive surgery). During these years three cases of endometrial cancer were detected in women of reproductive age that referred to us to solve their infertility problem.
No uterine perforation happened and only 2 cases needed to stay overnight in the hospital for surveillance. This shows the easiness and safeness of the procedure.

V 002

Laparoscopic operating by torsional ultra sound: from concept to reality in gynaecological laparoscopic surgery

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The torsional mode of applying ultrasonic energy to tissue has significant advantages over the traditional linear mode used in other ultrasonic cutting devices.This presentation explains the physical principles involved and describes the development of LOTUS in Gynaecological MAS at Derriford Hospital,Plymouth over the past four years,with video footage of a wide variety of laparoscopic procedures demonstrating its use.

V 003

Operative therapy of deep infiltrating endometriosis

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Introduction: The operative therapy of deep infiltrating endometriosis (DIE) in the cul-de-sac, the sacrouterine ligaments, the rectovaginal septum and in other locations requires skilled surgeons. When the intestine, the urinary bladder and/or the ureters are infiltrated an interdisciplinary surgical approach is needed.
Material and methods: The selected video samples show various laparoscopic techniques such as: CO2-Laser vaporization of peritoneal lesions, in toto resection or laser vaporization of endometriomas, resection of rectovaginal endometriosis with or without low anterior bowel resection, ureterolysis, ureter sutures and presacral neurectomy.
Results: Deep infiltration into structures such as the sacrouterine ligaments (65%), the vaginal wall (15%), the urinary bladder (7%), the ureter (1.5%) and the intestine (10%) is responsible for the devastating symptoms often associated with DIE. To guarantee symptom relief and to reduce the recurrence rate a radical operative therapy is more efficient than incomplete removal or debulking (e.g. bladder DIE recurrence rate 8% versus 79%).
Discussion: The radical laparoscopic resection performed by experienced and skilled surgeons is a minimal invasive, safe and effective technique to treat DIE and seems to justify a proactive management.

V 004

Total laparoscopic hysterectomy using ultrasonic shears

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This video presentation describes our initial experience with the recently launched Harmonic ACE curved shears as the key component of a simple two port technique of laparoscopic hysterectomy.
Harmonic ACE is the new version of laparoscopic 5mm shears designed to work specifically with the UltraCision Harmonic Scalpel Generator 300. It overcomes many of the perceived problems encountered when using the LCS5 shears with a faster rate of cutting and coagulation and improved haemostasis, allowing secure transection of larger vessels.
Earlier harmonic scalpel technology requires continuous moderation of grip force, tissue tension, power level and cutting edge by the surgeon.
Comprehensive redesign of the shears has resulted in an instrument which achieves a 50% improvement in cutting and haemostasis, up to a vessel diameter of 5mm. It retains many of the useful features of the LCS5.
The technique successfully combats the criticisms levelled at laparoscopic hysterectomy when compared to more traditional approaches in terms of operating time, complication rates, learning curve and instrumentation.

V 005

Laparoscopic subtotal hysterectomy using ultrasonic shears

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In this video presentation we demonstrate the technique of laparoscopic subtotal hysterectomy (LSH) using the new Harmonic ACE 5mm shears (Ethicon Endo Surgery).
Harmonic ACE is the new version of laparoscopic 5mm shears designed to work specifically with the UltraCision Harmonic Scalpel Generator 300. It overcomes many of the perceived problems encountered when using the LCS5 shears with a faster rate of cutting and coagulation and improved haemostasis, allowing secure transection of larger vessels.
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Comprehensive redesign of the shears has resulted in an instrument which achieves a 50% improvement in cutting and haemostasis, up to a vessel diameter of 5mm. It retains many of the useful features of the LCS5.
This video demonstrates a simple technique of laparoscopic subtotal hysterectomy. Uterine extraction is achieved using an electrically driven laparoscopic morcellator which requires extension of the secondary port from 5mm to 12mm. No further device, unipolar or otherwise is required to transect the uterocervical junction allowing seamless surgery through the minimum of ports.

V 006

Leiomyomas in unusual locations treated laparoscopically

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A 32 year old woman presented with intermittent pelvic pain not associated with menstural periods.
Her past medical history was unremarkable. She had two vaginal deliveries and had no gynaecological history of note.
Initial investigations included a transvaginal ultrasound that revealed two leiomyomas: one fundal intramural (5x4x6cm) and one posterior pedunculated (4x5x5cm).
These were taken as potential causes of her pelvic pain and she opted for a diagnostic laparoscopy with a view to proceed to laparoscopic myomectomy.
The diagnostic laparoscopy revealed indeed a fundal intramural leiomyoma.
Instead of the posterior pedunculated leiomyoma, we found a torted tumor resembling a leiomyoma arising from the greater omentum. In addition a smaller tumor (2x1cm) was found superomedial to the right external iliac artery.
Routine myomectomy was performed. Then, we coagulated the omental vessels supplying the presumed leiomyoma which was then excised using bipolar diathermy. Then the parietal peritoneum was opened and taking care to avoid the external iliac artery the second tumor was removed.
Histology of all tumor tissue revealed benign leiomyoma.
We assume that the intermittent pelvic pain was due to the torsion of the omental leiomyoma and are happy to report, that on follow up, the patient had complete resolution of her symptoms.

V 007

Total laparoscopic adenomyomectomy of juvenile cystic adenomyoma using hydro-ultrasonographic monitoring

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A 16-year-old-woman had a cystic adenomyoma located within the myometrium. She complained heavily dysmenorrhea, and medication was treated including nonsteroidal anti-inflammatory drugs and low dose oral contraceptives. In spite of our treatment, her dysmenorrhea has deteriorated gradually. After careful informed consent, a total laparoscopic resection of cystic adenomyoma was performed. An external appearance of her uterus is almost normal in laparoscopy. We devise a hydro-ultrasonographic monitoring method, which is a technique of transvaginal ultrasonography with peritoneal hydration of physiological saline. This method is useful for detecting the location of cystic adenomyoma. A total laparoscopic resection of cystic adenomyoma was performed successfully. Her dysmenorrhea disappeared in postoperative menstruation.
Adenomyosis is a benign proliferative disease of uterus characterized by contiguous spread of endometrial glands and stroma into the myometrium. It may have cystic spaces filled with blood. However, they are almost small, usually <0.5 cm in diameter and large adenomyotic cyst called cystic adenomyoma was rare. Cystic adenomyoma often causes severe pain, and medications are almost poor effective. Surgical treatment is therefore recommended to this disease. We report here a successful experience of laparoscopic approach and demonstrate a useful technique of hydro-ultrasonographic monitoring with video.

V 008

Intravaginal sling-plasty in vault prolapse

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The posterior intravaginal slingplasty was first reported by Petros as a minimal invasive procedure for the treatment of vault prolapse. This report is a prospective observational study that confirms the efficacy and safety of this new procedure. In this operation the IVS Tunneller is used to insert an 8 mm polypropylene tape between the perineum and the vaginal vault. The resulting artificial neoligament reinforces the atrophied uterosacral ligaments. The rectovaginal fascia and perineal body are then repaired by a technique that includes using a bridge of vaginal epithelium to strengthen the central vaginal epithelium at the point of maximum weakness. All patients were discharged home within 3 days. There were minimal surgical complications and no transfusions were required. The technique is safe, minimally invasive, has a short learning curve and the skills needed are those of any competent pelvic surgeon.

V 009

Operative hysteroscopy

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Compared with diagnostic hysteroscopy, the operative hysteroscopy requires a technically as well as personally higher effort. In the therapy of infertility the operative hysteroscopy has completely replaced conventional techniques, which in most of the cases required a laparotomy. This applies to the treatment of the uterus septus, of intrauterine adhesions and submucous myomas. For bleeding disorders, which cannot be conservatively treated, hysteroscopic surgery such as polypus or myoma resections or the endometrial ablation, constitute alternative, organ-retaining methods of treatment. Advantages of endoscopic techniques are minimal discomfort of the patients and the retaining of the organ. However, the operative hysteroscopy makes high demands on the surgeon since specific complications may occur which require a good knowledge of the safety aspects of this method. This video is intended as a guide and help for the acquisition of the techniques of operative hysteroscopy. With exakt indications and with consideration of all the safety aspects, the operative hysteroscopy is a great enrichment for the operative gynaecology.

V 010

Diagnostic office hysteroscopy

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Outpatient hysteroscopy is indicated in abnormal uterine bleedings, sonographically suspect endometrial findings, sterility and lost-IUD. Sometimes a hysteroscopy using a standard hysteroscope can be difficult in nulligravidae, in patients with a previous conisation or in older patients with a craurosis fornicis. In these cases the use of a minihysteroscope is necessary and helpful. The advantages of minihysteroscopy will be demonstrated: suited for patients with cervical stenosis, outpatient hysteroscopy is also possible in problem patients, minimal lesion of the cervical canal, painless procedure, paracervical block is only necessary in rare cases, high picture quality, endometrial biopsy is possible without further dilatation. disadvantages are: no angle lenses, – the exami-

nation of the cornua may sometimes be more difficult, experience in the diagnostic hysteroscopy with standard lenses is necessary, fragile system, for direct biopsy a dilatation for the working sheath is necessary. With help of the minihysteroscopy it is possible to evaluate intrauterine findings also in problem patients in the practice. Thus the minihysteroscopy increases the spectrum of minimal invasive diagnostic methods in gynaecology.

V 011

3D-laparoscopy in borderline ovarian tumors

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The choice of the surgical method of treatment in ovarian tumors depends on the results of preoperative investigation. The mean goal of the initial diagnostic is to establish as precisely as possible the benign or malignant nature of the tumor .Then laparotomy or laparoscopy may be proposed to the patient and the extension of surgical procedure should be thoroughly discussed. It may be particularly important in young women with ovarian tumors of borderline malignancy when the conservative treatment with sparing the fertility may be realized by minimally invasive surgery.
Routinely, in order to establish the diagnosis, the gynecologic examination with transvaginal ultrasonography, NMR and marker ca 125 are performed.
3 D imaging is the new method of ultrasonographic examination with the possibility of visualization of the tumor in 3 dimensions with digital reconstruction of the image.
3 D imaging may be particularly useful in the diagnostic of small ovarian cysts with endovegetations which sometimes are difficult to visualize with conventional sonography. Endovegetations without the other signs of malignancy may be characteristic for borderline tumors and laparoscopic treatment may be considered in selected cases in primary or recurrent tumors.
The video presents 3 D images of borderline tumors and technique of laparoscopic treatment.

V 012

Paravaginal repair using White's technique

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Objective: This study was undertaken to describe and evaluate the outcome of bilateral paravaginal repair using White's technique which is different from the commonly used technique in its incision and approach.
Design: Retrospective observational study with follow up objective and subjective assessment.
Setting: Weston General Hospital NHS Trust, Weston-super-Mare, UK.
Patients: Forty-seven women presented with anterior vaginal wall prolapse of grade II or more according to the halfway grading system. They were all treated with bilateral paravaginal repair, White's technique, between the years 1995 to 2002.
Intervention: Forty-seven women were recruited. The mean length of follow-up was 29.1 months. The anatomical support of the anterior vaginal wall, the vaginal vault, and upper vaginal wall were objectively assessed pre and post operatively using the above system. Subjective assessment was made through patient satisfaction questionnaire.
Results: The mean age of women included was 60.1 years. Anterior vaginal wall was supported at grade 0 in 40 women (85.1%). Vault and upper posterior vaginal wall were supported at grade 0 in 45 patients (95.7%). Recurrence of anterior vaginal wall prolapse occurred in 7 women (14.9%), 2 of those 7 had recurrence of vaginal vault prolapse (4.3%).
Prolapse symptoms completely subsided in 42 women. Complications included one case of intraoperative bleeding.
Conclusion: Bilateral vaginal paravaginal repair, White's technique, is an effective and safe. It provides an easy and adequate exposure to the paravaginal space. It has a good subjective and objective outcome.

V 013

Culdolaparoscopy: a multifunctional vaginal port

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At the present time there is a tendency to use reduced size trocars for operative laparoscopy. However, when working with small ports technical limitations may be encountered, especially related to visualization, irrigation or specimen extraction.
In view of this we developed a technique that we called culdolaparoscopy. Culdolaparoscopy entails the use of 3 or 5 mm abdominal instruments together with a large vaginal port, which is used for insufflation, visual purposes, introduction of operative instruments and specimen extraction. With this approach the functionality of the ports varies depending on the nature and stage of the surgical procedure. From 1998, we have used this technique in more than 100 cases including ovarian cystectomies, oophorectomies, salpingooophorectomies, myomectomies, appendectomies and cholecystectomies. Some oophorectomies were performed after vaginal hysterectomy in cases where vaginal extraction was not possible. In this case series we had only one case of postoperative fever after an ovarian cystectomy, which was diagnosed as drug-related fever. No other complications were observed in the immediate post-operative period or in the follow-up visits.
In conclusion, culdolaparoscopy is a simple and safe technique that avoids additional and larger abdominal ports, potentially decreasing morbidity associated with conventional laparoscopy while overcoming limitations of minilaparoscopy.