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POSTER PRESENTATIONS

TOPIC 1: ENDOMETRIOSIS

P001

An evaluation of outcomes and success of laparoscopic excision of Endometriosis.

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Introduction: Endometriosis is a common gynaecological disease found in women of reproductive age, the natural history of which is poorly understood. The prevalence ranges between 2–22%. The 'gold standard' diagnostic investigation is laparoscopy, one the reasons the epidemiology and prevalence of endometriosis is difficult to elucidate. The Cochrane collaboration and Royal College of Obstetricians and Gynaecologists suggest that surgery is a first line treatment for infertility and endometriomas only, with little mention of pain. Laparoscopic removal of endometriosis has been labelled a 'last resort' procedure to be contemplated when all medical options have filed. We report a study that looked at the efficacy of surgical excision of endometriosis and the role it has to play in the management of endometriosis.
Methods: A retrospective study of 100 consecutive patients who underwent 'laparoscopic excision of endometriosis' from the surgeon's operating theatre register between March 2001 and January 2004 at a District General Hospital in the UK. This study analysed the efficacy of laparoscopic removal of endometriosis including symptom response, re-operation rates and the need for further medical and surgical therapy. All patients were sent a questionnaire to complete, this included Visual Analogue Scores rating their pain and the improvement in their symptoms, to assess their quality of life prior to and post surgery.
Results: Mean age at surgery was 31.6±7.1 years. Fifty nine percent of women were nulliparous, 15% had one child and 26% had two or more children. All women had a diagnostic laparoscopy prior to surgery. Over 70% reported pain as presenting symptom. Median duration of symptoms was 4.6 years prior to surgery. Seventy three percent of patients had tried hormonal therapy prior to surgery. The disease stage as defined by the revised American Fertility Society (rAFS) classification system was recorded as follow: 4% as Stage I, 31% as Stage II, 37% as Stage III and 28% as Stage IV. Thirty three percent of women had infertility and/or endometriomas as indication for excision. Eighty one percent of women had adhesion requiring adhesiolysis at operation. The diagnosis of endometriosis was confirmed by histology in 87% of women. Fifty six percent of patients returned the questionnaires. Analysis of the data has shown there was statistically significant improvement in: symptoms, pain scores (from 8.9 to 4.4) and quality of life scores. Seventeen percent of patients required further hormonal therapy and 15% required further surgical intervention.
Conclusion: The primary finding of this study is that laparoscopic excision of endometriosis is safe and it significantly improves symptoms in the majority of women. This finding is in keeping with the growing body of data and studies already published. There was also significant improvement in quality of life after surgery and pain relief. This study found no significant link between pain scores and rAFS grade of disease thus supporting findings of previous published studies. Neither was there any relationship between grade and primary symptom resolution or grade and further intervention.

P002

Angiogenic activity in peritoneal form of endometriosis for a long-term prognosis.

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Objective: To evaluate the long-term prognosis in women with different angiogenic activity of peritoneal endometriosis.
Methods: Sixty patients of ages 22 to 35 years old with peritoneal endometriosis and infertility were recruited. The diagnosis of peritoneal endometriosis was confirmed by laparoscopy. Appearance of implant types as red, black and white was denoted. Blood samples and peritoneal fluid were collected from each woman. Samples were analysed using commercially available ELISA kits for vascular endothelial growth factor-A (VEGF-A) and its receptors: VEGF R1 and VEGF R2, according to the supplier's instructions. All the patients underwent surgery and used gnrh agonists for 4–6 months.
Results: All the patients were divided into two groups. The severity of pain syndromes, color and distribution of endometriotic lesions and the levels of angiogenic growth factors were evaluated. Patients of the first group had mild dismenorrhea (89,9%), mild dispareunia (90,2%) and mild

ovulation pain (78,9%). Peritoneal lesions tended to locate in utero-sacral ligaments (63,3%) and cul-de-sac (24,5%) with most in black (48,2%), white (9%) or combined "black-white" lesions (39,3%). Proangiogenic switch were registered (VEGF R2/ VEGF-A were significantly increased in 4 times compared to normal controls). The patients of the second group had severe pain syndromes (86,7%), combined "red-black" (42%), black (36%) or combined "red-black-white" (11%) lesions. VEGF R2/ VEGF-A ratio were increased in serum in 15–20 times, in peritoneal fluid in 3 times compared to controls. So, the degree of proangiogenic switch correlated with laparoscopic appearance of endometriotic lesions and the severity of complaints significantly. Endometriosis in patients with high angigenic activity (increase of VEGF R2/ VEGF-A ratio more than in 15 times) was defined as "active form of peritoneal endometriosis"; in patients with low angiogenic activity as "inactive form of peritoneal endometriosis". Pregnancy rate in women with active peritoneal endometriosis was 39, 4%, in women with inactive endometriosis form-77, 8%.
Conclusions: Angiogenic activity in patients with peritoneal endometriosis and infertility is an important criteria for long-term prognosis.

P003

Surgical treatment and angiogenic activity in women with peritoneal endometriosis and infertility.

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Objective: To evaluate surgical treatment influence on the angiogenic activity in patients with peritoneal endometriosis and infertility.
Methods: Sixty patients of ages 22 to 35 years old with peritoneal endometriosis and infertility were recruited. The diagnosis of peritoneal endometriosis was confirmed by laparoscopy. Appearance of implant types as red, black and white was denoted. Blood samples were collected from each woman before the surgery and two days later. Peritoneal fluid were collected during the surgery. Samples were analysed using commercially available ELISA kits for vascular endothelial growth factor-A (VEGF-A) and its receptors: VEGF R1 and VEGF R2, according to the supplier's instructions. All the patients underwent surgery (bipolar coagulation or excision of peritoneal implants, adhesiolysis) and used gnrh agonists for 4–6 months.
Results: All the patients were divided into two groups. Patients (34 women) who become pregnant in 12–24 months after treatment were included in the first group. The second group consisted of 26 women who didn't have pregnancy in 12–24 months. Peritoneal lesions in women of the first group tended to locate in utero-sacral ligaments (63,3%) and cul-de-sac (24,5%) with most in black (48,2%), white (9%) or combined "black-white" lesions (39,3%). Proangiogenic switch were registered (VEGF R2/ VEGF-A were significantly increased in 4 times compared to normal controls). The patients of the second group had combined "red-black" (42%), black (36%) or combined "red-black-white" (11%) lesions. VEGF R2/ VEGF-A ratio were increased in serum in 15–20 times, in peritoneal fluid in 3 times compared to controls. Surgery didn't significantly influence on the angiogenic balance: VEGF R2/ VEGF-A in the first group was registered as 25,8±6,7 before the surgery, 15,8±4,2 after, compared to controls (110,4±51,4). In second group ratio VEGF R2/ VEGF-A was 4,7±1,01 before and 10,9±2,1 after treatment.
Conclusions: Surgical treatment doesn't influence significantly on the angiogenic balance in women with peritoneal form of endometriosis and infertility.

P004

Outcome after rectum or sigmoid resection: a review for gynaecologists

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Introduction: It is still unclear when to perform a discoid or segmental bowel resection for large endometriotic nodules with intestinal invasion.
Methods: We reviewed in Medline the incidence of leakage and functional problems following anterior and sigmoid resection as reported in the surgical literature albeit for other indications.
Results: Endoscopic resection clearly is feasible but requires an experienced surgeon. The incidence of leakage is not different after hand sewn or staple anastomosis, but is higher after a low rectum resection than after a sigmoid resection. Functional bowel problems are higher after a low rectum resection than after sigmoid resection. Low rectum resection in addition can be associated with functional bladder problems and anorgasmia.
Discussion: In conclusion, complications are higher after a low rectum than after a sigmoid resection.

P005

Outcome of conservative laparoscopic surgery in advanced endometriosis: recurrence and consequences for infertility management.

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Introduction: Minor endometriosis and new cases are dealt with by general gynaecologists mostly. Patients suffering from recurrent or severe endometriosis are referred to an experienced laparoscopic surgeon in our hospital. Patients

operated upon laparoscopically for severe endometriosis have been evaluated retrospectively to reconsider guidelines for future management.
Methods: The surgery reports of all patients operated for endometriosis from 1999 up to 2004 were checked. All cases with endometriosis class 3 and 4 according to the American Fertility Classification were selected. The patient characteristics, previous treatments and the follow-up were traced down carefully. Statistical analysis was performed using SPSS 13.0. The Kaplan-Meyer method was used for calculation of the recurrence and pregnancy rates.
Results: Seventy-three patients fulfilled to the selection criteria and follow-up was complete in 72 cases. Forty-eight patients were classified as AFS 3 and 25 as AFS 4. Infertility was the main complaint and pains the second one. Patients with AFS 3 suffered from infertility in 77% and patients with AFS 4 in 100% of cases. In all cases with child wish operation was aimed to preserve fertility. All procedures started laparoscopically. In 8% was converted to laparotomy. AFS 4 patients had been treated before in 64% of cases and AFS 3 patients in 42%.
In both group the recurrence rate stabilized at 50% finally. For endometriosis class 3 this took 51 months but for class 4 it took 24 months. The number of spontaneous pregnancies still increased to the end of follow-up in the AFS 3 but stabilized after 2 years in the AFS 4 group. By adding IVF to the treatment a recurrence did not influence the overall change of pregnancy. Finally the pregnancy rate for the AFS 3 patients was over 80% and for AFS 4 over 50% (N.S.).
Discussion: Laparoscopic surgery is useful even in advanced cases that have been pre-treated before. For AFS 4 IVF should be offered at 2 years follow-up or in case of earlier recurrence, at that moment. For AFS 3 IVF can be postponed up to 4 years after surgery if free of recurrence.

P006

Pelvic adhesion formation after laparoscopic partial and total peritoneal excision for women with endometriosis

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Objective: To determine the incidence of pelvic adhesion formation at second-look surgery after laparoscopic excision of pelvic peritoneum for pelvic endometriosis.
Setting: A District Hospital in the United Kingdom with a specialised unit for laparoscopic surgical treatment of endometriosis.
Design: Retrospective study
Method: We used data from the hospital computer database to identify patients who had laparoscopic excision of pelvic endometriosis from April 1998 to March 2004. All subsequent admissions for surgery (laparoscopic or open) were reviewed for the presence of pelvic adhesions as documented in the records and collaborated with photographs from surgery.
Result: Forty-eight cases were identified from a cohort of 236 patients who initially had laparoscopic excision of pelvic peritoneum affected with endometriosis. Forty-six had laparoscopic surgery and two had open surgery. At second look surgery, 44 patients (91.7%) had no de-novo pelvic adhesions in the areas where the initial excision was performed. Four patients (8.3%) had filmy adhesions in the pelvis, these patients had other surgical procedures (two had LAVH) or on-going disease (one with recto-vaginal endometriosis nodule, and the other with ovarian endometrioma at initial surgery). There were no dense or significant pelvic adhesions.
Conclusion: Laparoscopic excision of pelvic peritoneum as treatment for pelvic peritoneal endometriosis is not associated with significant pelvic adhesion formation.

P007

Endometriosis in an Adolescent Population

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Introduction: To discuss the clinical features, diagnosis and treatment options of endometriosis in adolescents and to evaluate safety of laparoscopic management.
Methods: The records of adolescent patients (10–21 years) who were admitted in our Department for diagnostic and/or operative laparoscopy were selected. The symptoms prevalence, operative findings, and the response to surgery were retrospectively reviewed.
Results: Fifty-one teen-agers were submitted to laparoscopy. Endometriosis was detected in 16 (31.4%). The majority of patients (50%) presented with stage I. Only one patient presented with stage II (6.3%), 3 with stage III (18.8%), and 4 (25%) with stage IV. Out of the 16 girls, 14 (87.5%) complained of pain. All patients were treated laparoscopically without complications and the symptoms were relieved. There was no morbidity or mortality.
Discussion: Adolescent girls with pelvic pain have a high incidence of endometriosis. Severe dysmenorrhoea is the most relevant symptom. Laparoscopy should be carried out in all adolescents and teenagers with chronic pelvic pain unresponsive to medical treatment.

P008

The pains in endometriosis: related typologies of women

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Introduction: To evaluate endometriosis patients' symptoms and relate them to fertility and different stages of endometriosis.
Methods: 391 patients with endometriosis submitted to laparoscopy were studied. During laparoscopy 134 women were classified with stages I–II, 257 with stages III–IV. Presurgical symptoms (dysmenorrhoea, pelvic pain, and deep dyspareunia), recurrence of endometriosis, and pregnancy outcomes after laparoscopy were analysed in a long-term follow-up.
Results: Pelvic pain, dysmenorrhoea and recurrence of disease after laparoscopy were more relevant in late-stage endometriosis ($P<0.05$); infertility was the main indication to laparoscopy for early stages ($P<0.05$). Admission for pelvic pain and severe dysmenorrhoea was prevalent in patients desiderous of pregnancy before surgery who obtained a baby after ($P<0.05$) while pain recurrence was more frequently observed in patients desiderous of pregnancy but remain infertile. ($P<0.05$).
Discussion: Symptoms of endometriosis may predict the stage of endometriosis. Painful symptoms of endometriosis may suggest diagnosis in late-stage of endometriosis, infertility in early stage.

P009

Sentinel lymph node detection using vital dye is not a reliable technique in predicting lymphatic dissemination in patients with early endometrial cancer

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Objective: To examine the reliability of sentinel lymph nodes (SLNs) detection by Patent Blue Violet (PBV) pericervical injection in patients with endometrial cancer undergoing complete pelvic lymphadenectomy through laparotomy or laparoscopy in a multicenter prospective trial.
Design and Methods: Between September 2000 and May 2005 a total of 34 patients with early stage endometrial cancer underwent SLNs detection. PBV (4 ml) was injected directly into the substance of the cervix at 3, 6, 9, and 12 o'clock before surgery. SLNs assessment was done during laparoscopic-assisted vaginal hysterectomy (LAVH) or total abdominal hysterectomy (TAH) as the first step of systematic pelvic lymphadenectomy. In the cases where one or more blue-dyed lymph nodes were found, they were taken separately from the global anatomical material and sent for frozen section.
Results:
Pelvic lymph nodes dissection was initiated 20–30 min after PBV injection during LAVH and 40–50 min after PBV injection during TAH. Detection rate of SLNs by PBV was 82% in the LAVH patients and 41% in the TAH patients ($P=0.008$;chi-square test) with a global rate of 62% considering the all 34 patients. The majority of (SLNs) were found in the so-called "Leveuf et Godard" area. At the final pathology pelvic lymph node metastases were present in 6 out of 34 patients (18%) but no SLNs were detected by PBV in 2 (33%) out of these 6 patients.
Conclusions: SLN detection by PBV is not a reliable technique in predicting lymphatic spread in patients with early stage endometrial cancer because of the low detection rate.

P010

Laparoscopic treatment of deep endometriosis

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Objective: This is a retrospective study to evaluate the efficacy of complete laparoscopic excision of deep endometriosis with associated rectosigmoidal resection in any case of necessity in those women that present pelvic pain or infertility in terms of to achieve pregnancy and pain relief. The deep endometriosis is usually located on the uterosacral ligaments and rectovaginal septum.
Methods: Since January 1998 to May 2005, 64 patients with symptomatic deep infiltrating endometriosis (DIE) underwent laparoscopic surgery to perform radical and complete excision of DIE. The age range was 26–49 years. The symptomathology was mixed between dysmenorrea, dyspareunia and infertility. 2 patients presented pyelonephritis with ureteral affectation and 28 patients had retrouterines nodules. 32 of them have had previous laparotomies to treat the disease. Surgical procedure consisted of laparoscopic excision of all the lesions including sacrouterine ligaments resection (N:46) some of them with excision of rectovaginal nodules, segmental ureter ablation (N:1), partial cystectomy (N:1), rectosigmoidal resection (N:12), appendectomy (N:2), and between them total hysterectomy was performed in 16 patients and total hysterectomy with bilateral anexectomy in 9 patients.
Results: Of the 64 women, 4 of them presented minor postoperative complications (6.2%) like fever, abdominal distension, recto-sigmoidal stenosis and vesical atony. 2 patients (3.1%) had major complications including a rectovaginal fistula and an ureteral necrosis. The recurrence after 12 months requiring iterative surgery occurred in 2 patients (3.1%). The follow-up is not too long, but the postoperative pregnancy rate was 54.8% (17/31). 41.9% (13) had spontaneous pregnancy and 12.9% (4) through IVF. Pain relief was related by 86% (55).
Conclusion: Laparoscopic surgery of deep infiltrating endometriosis allowed a good outcome with favourable results regarding pain relief and infertility.
This pathology should be treated by multidisciplinary surgeons to perform a complete excision with few postoperative complications.

P011

Use of computerised pelvic mapping to identify markers for more extensive disease and difficulties of surgery.

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Reports from a specialist tertiary referral clinic have highlighted the observation that ovarian endometrioma rarely occurs in isolation. This study looks at the incidence of ovarian endometrioma and peritoneal disease in a pelvic pain clinic offering both a secondary and tertiary referral service.

All women referred to the clinic and who under went an operative laparoscopy, had their operative findings prospectively recorded on a specifically developed computer database, Endostat™. Intra operative findings recorded included location and appearance of endometriotic lesions, combined with the various components and calculation of their r-ASM scores. All women underwent laparoscopic radical excision of all visible lesions and positive diagnosis of endometriosis was made histologically with the presence of glands and stroma. Only women with intact gynaecological organs were included in the analysis. The study was performed between July 1999 and March 2005.

The study involved 697 operative laparoscopies. It was found that ovarian endometriosis which is diagnosable via ultrasound was a marker for peritoneal and nodular endometriosis in 92% (95%CI 89–94 SE 0.01) of cases. It was also associated with uterosacral disease in 97% (95% CI 95–98 SE 0.006) and bowel endometriosis in 40% (95% CI 37–44 SE 0.019) of the cases. Clinical examination was able to diagnose the presence of rectovaginal nodular disease with a positive predictive value of 93% and negative predictive value of 84%. In women with such lesions, in 6%, surgery involved disc resection with only 2 returns to theatre for secondary leakage with subsequent segmental resection and defunctioning colostomy. 6% had significant haemorrhage and 1% had a rectovaginal fistulae. Three cases underwent laparoscopic ureteric re-anastamosis with one case requiring subsequent secondary ureteric re-implantation.

Complications correlated with the anatomical location of disease and the presence of nodular disease with a p=0.0148 and 0.008 respectively but there was no correlation with r-ASM scores (p=0.546).

Ovarian endometrioma is a marker for endometriosis elsewhere in the pelvis and for women with pelvic pain, should not be treated in isolation. The presence of nodular utero-sacral disease can be detected by clinical examination in the majority of cases. The appearance and location of the disease rather than r-ASM correlated best with the difficulty of surgery, reflected by the complication rate. Women with ovarian endometriomata should be referred to specialist centres for assessment and treatment.

Reference

Redwine DB. 1999. Ovarian endometriosis: a marker for more extensive pelvic and intestinal disease. Fertil Steril 72 (2); 310–315.

TOPIC 2: GYNAECOLOGICAL ONCOLOGY

P012

Choriocarcinoma of the uterus with metastasis to the cervix and urinary bladder: a case report.

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We present a case of choriocarcinoma of the uterus with metastasis to the cervix and the urinary bladder. Who was diagnosed because of persistent abnormal uterine bleeding despite a diagnostic uterine curettage one year ago with a diagnosis of decidual reaction. The cytology report was cervical cancer. The patient was scheduled for hysterectomy because of a huge myomatous uterus and high beta hCG titers . At the time of operation masses on the uterine body and cervix and metastasis to the urinary bladder was seen. A hysterectomy was performed .The pathology report confirmed choriocarcinoma in the body of the uterus and cervix after she received EMACO chemotherapy. She had negative beta hCG values after that. Result: choriocarcinoma of he uterus maybe misdiagnosed as squamous cell carcinoma of the cervix so measurement of beta hCG appears to be useful in cases of abnormal uerine bleeding even with cytologic diagnosis.

P013

Sentinel Lymph Nodes and Radioguided Endoscopic Surgery in Endometrial Cancer Patients

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Introduction: Although the conception of sentinel lymph nodes plays definitely an important role in the management of breast and uterine cervix cancer the benefit of sampling lymphadenectomy remains still controversial in endometrial cancer. The aim of the study was to evaluate the feasibility of pre–and peroperative lymphoscintigraphy and radioguided surgery in endometrial cancer patients. Methods: The study group consisted of 33 patients with endometrial cancer. All of them were classified as FIGO stage I or II. 50 MBq of 99 mTe-nanocolloid divided into 4–6 portions was administered by a 25 gauge needle transcervically into the myometrium. The injections were guided directly by hysteroscopy or indirectly by vaginal ultrasonography. Series of static lymphoscintigrams were performed 20 to 90 min after injection. The surgery started 1to 2 hrs after injection. All patient underwent hysterectomy, bilateral salpingo-oophorectomy and pelvic or pelvic

plus paraaortal lymphadenectomy. The procedures were performed as open or endoscopic surgeries. A handheld or laparoscopic gamma probe was used to locate positive lymph nodes. Each hot node was removed separately.
Results: Sentinel lymph nodes were identified in 27 (82%) patients. The mean number of sentinel nodes found was 2,9 (range 1–10). Only 72 of 472 nodes obtained were radiocolloid positive. In 5 of those (7%), metastases were found on subsequent histopathologic examination. In 6 patients (18%) sentinel nodes were not detected during the operation. Most of sentinel nodes detection failures were in patients with deep myometrial invasion or with macroscopically enlarged nodes.
Discussion: The detection failure seems to be related to the blockade of lymphatic drainage into the metastatically enlarged nodes or due to the escape of radioactive colloid into the blood circulation at advanced uterine cancers. The gamma probe guided sentinel node biopsy may contribute to the management of endometrial cancer. It may increase the accuracy of peroperative staging and reduce morbidity associated with extensive systematic lymphadenectomies.

P014

Usefulness of Doppler index, CA125 and TPS in preoperative diagnosis of ovarian functional cysts

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Objective: The purpose of the study was to evaluate the usefulness of Doppler index (SD), and selected biochemical markers (CA125 and TPS) in preoperative diagnosis of ovarian functional cysts.
Design & Methods: 117 patients with adnexal tumors (67 functional) diagnosed and treated in our Department were analyzed. At the admission the patient underwent ultrasonographical examination using the Doppler scale (SD) created in gynecological service in Poznan. Serum levels of CA125 (63 patients) and TPS (52 patients) were determined. Doppler scale (SD) (0–5 points) consists of 5 features: number of vessels, their location and arrangement, shape of velocity waves as well as presence of the protodiastolic notch in the arterial vessels of the tumor. After Doppler and biochemical evaluation patients were operated by laparoscopy or laparotomy. Obtained data were statistically analyzed.
Results: Doppler scale (SD) for cut off value of 4 points demonstrated prognostic values: accuracy-ACC=58,1%; sensitivity-SENS=98.3%; specificity-SPEC=15,8%; positive predictive value-PPV=55.0%; negative predictive value-NPV=69,2%, respectively in prediction of functional character of diagnosed cysts. The same statistical parameters for CA125 serum concentration cut off value 35 U/ml and TPS serum concentrations-90 U/l were: $ACC_{(CA125)}$= 55,5% and $ACC_{(TPS)}$=34,6%, $SENS_{(CA125)}$=86,7% and $SENS_{(TPS)}$=73,9%, $SPEC_{(CA125)}$=27,3% and $SPEC_{(TPS)}$= 3,4%, $PPV_{(CA125)}$=52,0% and $PPV_{(TPS)}$=37,8%, $NPV_{(CA125)}$= 69,2% and $NPV_{(TPS)}$14,3%, respectively.
Conclusions: Doppler index and especially biochemical markers serum concentration analysis have low accuracy and specificity in diagnosis of ovarian functional cysts. This methods are not recommended as a first line diagnosis methods for functional ovarian cysts.

P015

Usefulness of artificial neural network in preoperative diagnosis of ovarian tumors malignancy and in qualifying for endoscopic Surgery

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Objective: The aim of the study was to evaluate the usefulness of neural model for ovarian tumors malignancy prediction.
Design & Methods: 686 women with adnexal masses were analyzed. Following characteristics were considered: age, menopausal status, BMI, grayscale and Doppler ultrasonography features and tumor marker levels (CA125, TPS-Tissue Polypeptide Specific Antigen). Probability of benign and malignant ovarian tumor was calculated with artificial neural network software. Using Receiver-Operating Characteristics curve diagnostic efficiency of received model was estimated.
Results: 431 (62.8%) patients had benign and 255 (37.2%) patients had malignant ovarian tumor. Significant malignancy predictors were: age, menopausal status, maximal tumor diameter, internal wall structure, septa, tumor localization, solid elements, vessels localization and blood flow indexes. Tumor markers concentration were not included to the predictive model. The best neuronal network gave sensitivity-96.0% and specificity-97.7%. The area under ROC curve for received model was 0.9716.
Conclusions: The artificial neural network model based on clinical and ultrasonographic data enables to calculate probability of tumor malignancy and support decision making concerning selection of the most suitable operative treatment-endoscopy or laparotomy.

P016

The usefulness of sonomorphological index in preoperative diagnosis of functional ovarian tumors

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Objective: The purpose of the study was to evaluate the usefulness of sonomorphological index in preoperative diagnosis of functional ovarian tumors and classifying patients for endoscopic surgery.
Design & Methods: 167 premenopausal patients with adnexal tumors diagnosed and treated in our Division in 2000–2005, were analyzed. At the admission patient underwent an ultrasonographical examination which stated morphology of tumor using the sonomorphological index (SM). The cut-off value fixed at 8 points for this index, created in gynecological service in Poznan, discriminates the most precisely malignant (≥8 pts) and benign (<8 pts) tumors.
Results: Patients with ≥8 pts in SM (n=45) were operated after first ultrasonography, and 4 of them were histopatologicaly confirmed as functional (3-follicular cyst, 1-haemorrhagic cyst). Tumors with <8 pts in SM (n=121) were observed for three month and had second ultrasound exam. 86 tumors were persistent and all of this patients were also operated. 35 (40.7%) tumors have disappeared and were considered as functional. Among functional tumors (n=83) following histopathological types were identified: 21 cases of follicular cyst (25.3%), 16 cases of luteal cyst (19.3%) and 11 cases of haemorrhagic cyst (13.2%). For functional tumors the sonomorphological index demonstrated following prognostic values; sensitivity-95.2%; specificity-50.0%, accuracy-72.4%, positive and negative predictive value-65.3% and 91.1%, respectively.
Conclusions: Sonomorphological index (SM) is helpful in preoperative diagnosis of functional ovarian tumors in premenopausal women. It supports decision making in selection patients for endoscopic treatment.

P017

Role of operative laparoscopy in the treatment of ovarian cancer

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The role of operative laparoscopy in the treatment of ovarian cancer strongly is discussed from two currents of thought: pioneers-if adequately performed it can be proposed for all patients-, conservatives-difficult procedure for expert laparoscopic surgeons and no long term data to demostrate similar survival after laparotomy or laparoscopy. From 2003 to 2004 we submitted to lps 56 patients for ovarian cancer: 6 (12,5%) for I debulking, 13 (32,2%) for II cytoreduction or II lps look, 36 (64,2%9) for laparoscopic restaging.
The overage age was 36 years (20–75), the operative time was 120 minutes (40–330), the hospital stay, in days, was 2 days and the overages blood loos was 50 ml (10–400). The complication rate was 12,5% -six cases of fever and one case of inferior limb lynpf edema-.
The laparoscopic potential risks are: tumor dissemination and port-side metastasis, to decrease this risk we must reduce aerosolization of malignant cells by screwing the trocars to avoid continuous desufflation, desufflating all CO2 before removing the trocars, skin and subcutaneous tissue should be irrigated with povidone iodine and all wound tissue planes should be sutured.
The contraindications to operative laparoscopy in the treatment of ovarian cancer are: external vegetations and bulky nodes.
Final comments: the negative results so far reported reflect the potential risk of the procedure when used by inexpert physicians, the laparoscopic staging is feasible, but there are no data on the impact on survival The technique has the potential to be as accurate as laparotomy in surgical staging of presumed early ovarian cancer, properly design clinical trials should prove its safety and reproducibility before its definitive propagation, outside this setting, laparotomic staging remains gold standard in ovarian cancer.

P018

Diagnostic hysteroscopy in women receiving Tamoxifen

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Objective: To evaluate the endometrial changes in women receiving tamoxifen as an adjuvant treatment for breast cancer using diagnostic hysteroscopy.
Materials-Methods: 68 women (age 44–76 y, mean age 64 y) receiving tamoxifen (20 mg/day) as adjuvant breast cancer treatment for at least one year were presented to the outpatient clinic of our department in order to evaluate possible endometrial lesions. Of these women 44 (65%) were postmenopausal and 24 were premenopausal. 48 were symptomatic (they had abnormal uterine bleeding-29 of them were postmenopausal) and the others came for routine examination. After the clinical and ultrasonographic examination all of these patients underwent diagnostic hysteroscopy followed by histologic endometrial sampling.
Results: In the symptomatic postmenopausal group our hysteroscopic findings were: 15 cases with suspicious or malignant changes which were confirmed by histology (8 atypical hyperplasias, 7 endometrial carcinomas). 3 cases with simple hyperplasias and 11 cases of atrophic endometrium. In the symptomatic premenopausal group the findings were: hyperplasia (17 cases) co-existing with polyps in 8 cases, fibromyoma (1 case) and carcinoma (1 case).
All the asymptomatic postmenopausal women (15) had atrophic endometrium,while the findings in the premenopausal women were:normal endometrium (4 cases) and 1 polyp.
Conclusions: The estrogenic and hyperplastic effect of tamoxifen, especially when it is used as a long-term treatment, is well documented. Hysteroscopic evaluation of women receiving tamoxifen can lead us to accurate diagnosis of endometrial lesions. We can propose a regular screening of these patients including hysteroscopy and

histologic assessment of the endometrium, so as the atypical or malignant changes could be identified as soon as possible.

P019

The histological dilemma- metaplasia or cancer

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Introduction
Tubal and tuboendometriod metaplasia may present on a smear as dyskaryotic glandular cells.
Case scenario
A 38 year old lady presented with severe dyskaryosis on her cervical smear. Colposcopic assessment was unsatisfactory: therefore a diagnostic loop biopsy was taken. Histology revealed 2 distinctive elements- a single focus of definite superficial cervical endometriosis and an adjacent area that was difficult to interpret. The sections were reviewed by several pathologists who reported a focus of high grade CGIN and a focus with the features suggestive of early invasion. The hob nail pattern suggested that this was a clear cell lesion.
The subsequent cone biopsy showed no evidence of invasive clear cell lesion. There was residual endometriosis, tuboendometriod metaplasia and CGIN.
Discussion
This case illustrates difficulties in interpretation of endometriosis on smears. Endometrial cells on cytology may be misinterpreted as dyskaryotic glandular cells and histology may be confused with tuboendometroid metaplasia.
The loop biopsy showed an irregular gland pattern, and hob nail pattern suggestive of clear cell carcinoma. The absence of convincing stromal invasion and of generalized mitosis and nuclear atypia on cone biopsy suggested clear cell metaplasia and not carcinoma. These two conditions despite having relatively similar microscopic images have obviously different prognosis and management.
Tuboendometriod metalpasia is fairly common and may mimic CGIN. Clear cell metaplasia is extremely uncommon and usually develops in glandular epithelium and endometrium. Absence of mitoses, nuclear atypia and stromal invasion can help support the diagnosis of metaplasia.

P020

Cervical Polyp or Uterine Adenosarcoma- A Case Report

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Introduction
Uterine adenosarcomas are rare biphasic tumours of low-grade malignancy with benign epithelium and malignant stromal components. They belong to the family of mixed mesodermal mullerian tumours (MMMT). When an adenosarcoma occurs in the cervix or is protruding from the cervical os, it may be misdiagnosed as a benign cervical polyp. This confusion occurs because of macroscopic and microscopic similarities between both lesions by clinicians and pathologists. We report a case of adenosarcoma presenting as a benign appearing cervical polyp and a review of the literature.

P021

Vulval Sarcomas with benign presentation-a case series

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Introduction
Vulval sarcomas comprise 1–3% of vulval malignancies and leiomyosarcomas account for about 0.33% of these.
We present 3 documented cases in the last year with long-standing benign looking vulval fibroids causing difficulty in diagnosis and a review of the literature.
Study design: Documented cases of leiomyosarcoma were reviewed from the Dept. of Pathology database.
Results: 3 multiparous patients in the age group of 35–55 are discussed. They all had a long-standing history of a vulval lump which was suddenly changing character, warranting investigation.
Diagnostic difficulties were encountered due to varying immunohistochemistry and staining of the tumour requiring international reviews on the final diagnosis of these lesions.
Longstanding vulval disease with sudden change in character prompting patients to seek advice should alert one to the possibility of malignant transformation.
These cases illustrates the rapid growth of vulvosarcoma which in our patient grew to a 7 cms lump following resection from a 3 cms lump in a 4 month period while awaiting final diagnosis
Accurate diagnosis is important to tailor appropriate treatment as treatment for benign lesions, carcinoma and sarcomas are different.
Histology and immunohistochemistry played a major role in confirming diagnosis in this patient.
As these cases illustrates, proper and expert interpretation of histology and immunohistochemistry is important for definitve diagnosis as lumpectomy would suffice for a benign lump but mutilating vulvectomy is needed for malignant tumours.

P022

Vaginal radical trachelectomy: results of pregnancy and recurrence

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Vaginal radical trachelectomy with laparoscopic parametrectomy and pelvic lymphadenectomy consists one treatment's options of cervical cancer. Dargent proposed and began this surgery in 1987.
Objective: To identify recurrence and pregnancy in patients submitted a conservative fertility surgery in cervical cancer.
Patients and Methods: The surgery was indicated in six patients who desire to preserve fertility, with tumor less 2 cm, stage FIGO Ia2 to Ib1, hystologic type epidermoid or adenocarcinoma and up cervical channel free. One patient had positive sentinel node, and the surgery was aborted. Five patients were submitted a vaginal radical trachelectomy with laparoscopic parametrectomy and lymphadenectomy between 2000 and 2004.
Results: The five patients were Ib1 FIGO stage, four epidermoid and one adenocarcinoma. The follow-up is 24 to 70 months. No recurrence was identified. One patient had a pregnancy with live birth baby at 29 weeks, baby at home. Another patient had two pregnancies: one lost with 23 weeks (ovular infection) and one pregnancy with live birth baby, 30 weeks, baby at home. One patient had a pregnancy lost with 24 weeks, and two patients don't want to be pregnant yet.
Conclusions: This surgery seems to be safety for some early cervical cancer (no recurrence in 24–70 months), and the rates of pregnancy and baby at home are similars to the literature. Because most of cervical cancer are diagnosed at advanced stage in our country, these results can be used to encourage the women to find public and private services to early diagnosis in cervical cancer.

P023

Laparoscopic pelvic lymphadenectomy in patients with cervical cancer

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Objectives: To determine the average of linfonodes at the laparocopic pelvic lymphadenectomy in the treatment of cervical cancer. To compare with the average of linfonodes at historical serie by laparotomy (Wertheim-Meigs).
Patients and Methods: Patients with cervical cancer stage FIGO Ia2, Ib1 and IIa submitted a vaginal laparoscopic radical hysterectomy, from january 2001 to december 2005. The laparoscopic time consisted of pelvic lymphadenectomy, cauterization and section of uterine vessels, preparation of vesical and pararetctal spaces, parametrectomy, salpingectomy and section of para-ovarian ligaments. The linfonodes were sent separeted, left and right sides, to the pathologist. The number of linfonodes, the metastasis and the complications were registered. The average of the linfonodes was compared with the average of linfonodes at the Wertheim-Meigs realized by the author (same surgeon) and the co-author.
Results: Fifty three cases of laparoscopic lymphadenectomy resulted in 1.241 linfonodes, with a average of 23,4. The average of linfonodes by laparotomy was 21,4. Three conversions ocurred: two by bleeding, one by technique problems.
Conclusions: The average of linfonodes by laparoscopy was greater than laparotomy, but without significant difference. The laparoscopic lymphadenectomy is safety: no severe complications ocurred.

P024

Sentinel node detection with patent blue in patients with cervical cancer

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Introduction: Pelvic node metastasis is the most significant prognostic factor in early cervical cancer. Sentinel node (SN) detection techniques are on study, and the hypothesis is: if SN is negative, the pelvic nodes are negatives.
Objective: To analyse the feasibility of sentinel node (SN) identification using patent blue in patients undergoing laparoscopy surgery for cervical cancer.
Material: Forty two consecutive patients with colposcopic cervical cancer stage IA2 and IB1, submitted to laparoscopy surgery from january 2001 to december 2005. Sentinel nodes were detected using a solution of 2 ml patent blue and 2 ml saline, and 1 ml was injected in each cardinal point of the cervix. One or more SN detected are removed for pathological assessment during the pelvic lymphadenectomy.
Results: In forty two patients, SN were detected in thirty two, with a detection rate of 76,2%. Eleven patients had bilateral SN; twenty patients, unilateral. Positive SN occurred in six (14%) patients, and the radical surgery were aborted. When the SN was negative, the others linfonodes were negatives.
Conclusions: The injection of patent blue was successful to detect SN in 76,2%, and identify women in whom radical hysterectomy and pelvic lymphadenectomy can be avoided. It's important to analyse this technique because is easier and less expensive than others.

P025

Laparoscopic Approach Of Large Ovarian Cysts: Feasibility And Safety

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Objective: To evaluate the laparoscopic approach for the treatment of ovarian cysts of large dimensions.
Methods: Data on all patients operated from 2003 in our Department for ovarian cysts larger than 10 cm of diameter were collected. Women were allocated to the laparoscopic (LPS) or laparotomic (LPT) group with regard to the initial surgical approach. Intra- and postoperative details, histology and follow-up data were recorded. Statistical analysis was performed with Student's t test, Mann-Whitney u test or Fisher exact test as appropriate.
Results: Sixty women were included: 49 (81.7%) in the LPS and 11 (18.3%) in the LPT group. Median (range) cyst diameter was 12 (10–40) and 20 (10–30) cm (p=0.04) in the LPS and LPT groups respectively. Bilateral cysts were observed in 7 (11.7%) patients. Malignancy and borderline tumors were finally diagnosed in 17 (28.3%) and 3 (5%) cases respectively. Median diameter of benign cysts was 12 (10–20) cm vs. 15 (10–40) cm of malignant or borderline cysts (p=0.03). In 9/49 (18.4%) patients managed with LPS, frozen section examination revealed an ovarian cancer: 3 of them had a disease macroscopically limited to the ovary and received comprehensive surgical staging with LPS during the same operation (i.e.: omentectomy, pelvic and paraortic systematic lymphadenectomy). Other 4 patients who received the diagnosis of malignancy at final histology and who had no evidence of metastatic disease were surgically staged with LPS 10 to 21 days after primary surgery. Six out of 49 (12.2%) LPS procedures were converted to LPT, all because of the diagnosis of an advanced stage ovarian cancer. Four cases of malignancy were completely managed laparotomically. No intra- or postoperative complication was registered.
Conclusions: Laparoscopy represents a feasible and safe approach to ovarian cysts of large dimensions. Moreover, in case of diagnosis at frozen section of an ovarian cancer apparently limited to the ovaries, it allows the performance of an accurate and comprehensive surgical staging during the same operation.

P026

240 patients with endometrial cancer: a comparison between the laparoscopy and laparotomy

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Introduction: Some recent publications have shown that laparoscopic surgery might be an acceptable alternative to conventional surgery in endometrial cancer. However, some opponents to the technique claim that there is a steep learning curve. The aim of the present study was to compare the results obtained in our first series of laparoscopic surgeries performed for endometrial cancer to the classical approach by laparotomy.
Methods: Retrospective analysis of patients with endometrial cancer who were treated between 1988 and 1996 (laparotomy=group 1) and between 1996 and 2006 (laparoscopy=group 2). The patients of both groups underwent a hysterectomy, bilateral salpingo-oophorectomy and if necessary a pelvic and/or paraaortal lymphadenectomy. The operating time, morbidity, blood loss and number of recovered lymph nodes were compared between both groups. The patients were followed after 3 and 6 months, and then every 6 months. For statistical purpose a t-student test was used.
Results: During the study period 240 patients could be included in the study. 120 patients were operated by laparoscopy and 120 by laparotomy. The median age (65.9± 12.3 yrs for group 1 resp. 64.9±9.0 yrs for group 2) and the BMI (29.6±6.9 kg/m^2 for group 1 resp. 31.6±7.4 kg/m^2 for group 2) were similar in both groups. There was no statistically significant difference in the average operating time (150±51 minutes for group 1 vs. 165±68 min for group 2). The intraoperative blood loss was significantly higher in the laparotomy group: estimated bloodloss 580± 457 ml in group 1 vs. 240±321 ml in group 2 ($p<0.001$). The number of recovered lymph nodes was significantly higher in the laparoscopy group (21.2 vs. 18.1, $p<0.05$). There were no statistically differences between the postoperative FIGO stages, 89% were classified as FIGO I or II in both groups. The hospital stay was significantly higher after laparotomy (13.2±3.7 days) than laparoscopy (5.6± 4.2 days), $p<0.001$.
Discussion: approach in the treatment of endometrial cancer and that in the hands of experienced laparoscopic surgeons, there is no significant learning curve. Furthermore, the age and weight of the patients should not be used as contraindication for the laparoscopy.

P027

Laparoscopic approach and its role in staging of early ovarian cancer: a case report

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Introduction: Accurate staging of ovarian cancer is of paramount importance in determining correct treatment and prognosis. This case demonstrates the value of laparoscopy in visualizing very early metastatic carcinomas in the upper abdomen and diaphgram and therefore the potential role of laparoscopy in the staging process.
Materials and methods: A case of a 56-year old nulliparous woman.
Case history: A 56 year-old patient was referred complaining of postmenopausal bleeding. She had a normal endometrial pipelle and cervical smear.A pelvic ultrasound showed Endometrial Thickness of 2 mm, a left ovarian septated cyst with solid component of 3×2.9×2.5 cms and a normal right ovary. Ca-125 was 11(RMI<99) A laparoscopy revealed an enlarged, multicystic left ovary and an enlarged right ovary, as well as a single, small right

diaphragmatic nodule (<3 mm) (photographs available). Immediate laparotomy with total abdominal hysterectomy, bilateral oophorectomy and omentectomy confirmed no other macroscopic tumour. Histology showed bilateral poorly differentiated endometrioid ovarian carcinoma with a single metastasis in diaphragmatic biopsy and the omental biopsy clear of tumor. Peritoneal washings sent for cytology were clear. Adjuvant chemotherapy was offered, followed by a postoperative CT thorax/abdomen/pelvis and post-operative tumour markers showing no residual disease. Because of complaints of lower abdominal pain four years afterwards, she had a second-look laparoscopy which showed pelvic adhesions, with no evidence of recurrence.
Conclusion: Although laparotomy remains the gold-standard for the staging of ovarian cancer, the role of laparoscopy needs to be considered during the staging process. Further well-designed research is required to establish this role.

TOPIC 3: HYSTERECTOMY

P028

Hysterectomy short-term outcomes in patients with similar indications

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Objective: To investigate the cost advantages and short-term complication rates associated with surgical routes of uncomplicated hysterectomies in which uteri size less than 9 weeks and benign diseases are confined to the uterus.
Methods: Randomized prospective study of short- term outcome. Data were collected prospectively from 2004 to 2005 from 40 consecutive women who had hysterectomies at a single institution. Women who had laparoscopically assisted vaginal hysterectomies (13), or vaginal hysterectomies (27) were selected if they had benign diseases confined to the uterus (adenomyosis, leiomyomas, abnormal uterine bleeding and prolapse). We compared length of operation, stay, hospital charges, and associated complications between the groups.
Results: Length of the laparoscopically assisted vaginal hysterectomies was significantly higher than length of vaginal hysterectomies (84,34±10,23 min 52.3±9.21 min, respectively). There were no significant differences between intraoperative blood loss (80–320 ml). There were no postoperative complications neither in the first group no in the second. The subfebrile fever was registered in 12, 3% of women during first three days, and in 3,5% during first 5 days. Length of stay was 4–5 days in patients of both groups. The median charges for laparoscopically assisted vaginal hysterectomies was 1, 7 times higher than for vaginal hysterectomies.
Conclusions: The vaginal route is a safe, feasible, and patient-friendly method of performing a hysterectomy if there is a vaginal prolaps. Laparoscopically assisted vaginal hysterectomies haven't significant clinical advantages compared to vaginal hysterectomies. The vaginal route has obvious cost advantages. The main aim of the laparoscopically assisted vaginal hysterectomies is the evaluation of the pelvic organs pathology and pelvic adhesions stage. The most important thing is the adhesions with the rectosygmoid colon and cul-de sac.

P029

The rational choice of surgical approach for hysterectomy

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In order to provide rationale for surgical approach in laparoscopic, mini-laparotomic and vaginal hysterectomy we analyzed the clinical features of postoperative period in patients with benign uterine tumors who had indications for hysterectomy. Laparascopic hysterectomies were performed in the study group (group 1, n=109). The control groups were patients after laparotomic (group 2, n=50) and laparoscopy-assisted mini-laparotomic (group 3, n=50) hysterectomies, and patients without colpoptosis, who underwent vaginal hysterectomy (group 4, n=36). The study was carried out in 2002–2006.
The mean age of patients in groups 1–4 was 48±5.3, 45.6±4.2, 43.6±7.9 and 54±3.5 years, respectively. The mean duration of surgical intervention was 137±33, 91.3±11.6, 114±11.2 and 46±5.9 minutes. respectively. The mean size of extracted uterus was 10.2±2.9, 16.6±4.1, 9.4±1.9 and 7.4±2.6 weeks of pregnancy; the mean weight-417±12.1, 772±23.3, 393±16.2 and 317±18.8 g. The mean intraoperational blood loss was 87.3±84.3, 392±57, 71.6±8.1 and 41.5±12.1 ml. The mean time spent in the clinic after surgery was 6.8±1.3, 9.2±1.6, 6.1±0.1 and 4.7±1.1 days. We observed complications in 4 patients (4.3%) of group 1: infiltration of vaginal stump, hematic abscess adjacent to vaginal stump, vesicovaginal fistula and ureterovaginal fistula. Similar complications were observed in 9.4% patients in group 2, 5.0% patients in group 3 and 3.8% patients in group 4.
Thus, in hysterectomy for adenomyosis, recurrent endometrial hyperplasia coupled with uterine leiomyoma and adenomyosis, or typical localization uterine leiomyoma not exceeding 15–16 weeks of pregnancy, the method of choice is total laparoscopic hysterectomy. In case of atypical (cervical, isthmical or interligamentous) myoma-

tous nodes, or large nodes of any localization, or cicatrical adhesions in parametrium and shortening of uterine ligaments, laparoscopy-assisted mini-laparotomic hysterectomy is preferred. Conventional laparotomy should be used for hysterectomy in patients with uterine size exceeding 18–20 weeks of pregnancy, severe adhesions, widespread pathology involving adjacent organs, gynecologic malignancy assuming an extended surgery is planned, or in patients with contraindications to laparoscopy due to concomitant disease. Vaginal hysterectomy is preferred in patients with combined pathology of the pelvic floor and incontinence. The use of appropriate methods on the basis of careful evaluation of the indications for the procedure allow the best results. Most hysterectomies may be, and should be performed as laparoscopic operations.

P030

Cervical bleeding after abdominal and laparoscopic subtotal hysterectomies

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Objective: To compare sutotal abdominal hysterectomy and subtotal laparoscopic hysterectomy performed for benign uterine diseases for 3–8 years follow-up.
Methods: 468 women aged 34–59 years old referred for benign uterine diseases (leiomyoma (78%), endometrial hyperplasia (15,3%) and adenomyosis (6,7%)) were randomised to subtotal abdominal hysterectomy (n=248 (53%)) or subtotal laparoscopic hysterectomy (n=220 (47%)) from 1997 to 2002. During all the surgeries endocervical coagulation and resection were performed. For the evaluation of the cervix pathology colposcopy, conventional cervical cytology or, if necessary, colposcopic biopsy and curettages were used.
Results: After subtotal abdominal hysterectomy, 10, 5% (n=26) of women and 6, 8 % (n=15) women after laparoscopic hysterectomy had bleeding. From them, 22 patients (84,6%) after abdominal subtotal hysterectomy and 12 patients (80%) after subtotal laparoscopic hysterectomy had a cyclic vaginal bleeding. All of women evaluated this symptom presence positively. The most frequently cyclic bleeding was registered during first three years after operation (77% after abdominal and 82% of patients after laparoscopic hysterectomies). Benign cervical pathology (chronic cervicitis) were diagnosed in 13,6% after abdominal and in 20% after laparoscopic hysterectomies. Cervix was removed in 0,8% after abdominal and in 0,9% after laparoscopic hysterectomy. Histologic results were endometriosis (71%) and cervicitis (29%).
Conclusions: Subtotal hysterectomy should be recommended in the cases of benign uterine and cervical pathology. It's very important to perform thorough cervix pathology investigation. When subtotal hysterectomy is necessary, it can be performed with a low rate of long term complications. If there is adenomyosis the rate of the cyclic bleeding after subtotal hysterectomy increases. Laparoscopic subtotal hysterectomy with endocervocal coagulation and resection leads to the decrease rate of the cyclic bleeding.

P031

Surgical routes of the cervical stump removal.

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Objective: The aim of the study was to analyse the surgical routes of cervical stump removal after previous supracervical hysterectomies.
Methods: Of 10 patients with a history of supracervical hysterectomy for adenomyosis and leiomyoma who subsequently required trachelectomy were included in the study.
Results: The indication for trachelectomy in all the cases was pain continuing for 5–7 years after the supracervical hysterectomy due to cervical endometriosis. It was impossible to correct it conservatively. We planned a vaginal route in all the cases. But only 7 of the 10 trachelectomies (70%) were performed by the vaginal approach. 3 of the patients needed laparoscopic assistance for adhesiolysis because of the severe cul-de-sac adhesions. Histological findings showed endometriosis and fibrosis in all the patients.
Conclusion: It's possible to perform trachelectomy by the vaginal approach. But if there is a severe pelvic adhesions it's necessary to use laparoscopic assistance for the evaluation of the adhesion stage and performing adhesyolisis.

P032

The impact of vaginal surgery training on the vaginal vs. abdominal hysterectomy ratio

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Introduction: Hysterectomy is one of the most often performed gynecological operations. The vaginal hysterectomy (VH) becomes more and more popular because of its advantages vs. abdominal hysterectomy (AH).
Objectives: To present the impact of learning curve on vaginal vs. abdominal hysterectomy ratio.

Material and methods: We present a retrospective analysis of 925 hysterectomies (with or without salpingo-oophorectomy) performed Between June 2001 and July 2005 because of benign conditions in our Department.
Results: A total number of 925 hysterectomies were performed, among them 214 (23,09%) in abdominal and 626 (67,75%) in vaginal way. Laparoscopically assisted vaginal hysterectomies were performed (LAVH) in 85 cases (9,13%).
At the beginning of the learning curve, the abdominal to vaginal operations ratio was 79,7% to 15,9%. After one year, the VH rate increased to 71,6%, compared to 14,8% of (AH). In another 18 months AH ratio reached a plateau at 79–80%. The rate of LAVH remained at the level of 6–8%.
Discussion: A systematic training in vaginal surgery significantly increased the vaginal hysterectomy rate. A 2–3-year period seems to be adequate to achieve results comparable to those of the world's leading centers. Vaginal hysterectomy can be performed in 8 out of 10 patients with benign conditions.

P033

Operative outcomes following total laparoscopic hysterectomy: a case series

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Introduction
The purpose of the study was to determine the operative outcomes for women undergoing total laparoscopic hysterectomy
Methods
The study involved a review of casenotes of a Retrospective Cohort in a tertiary referral centre for the management of advanced endometriosis The study involved all patients who had undergone Total Laparoscopic Hysterectomy at the hospital during the first two years since it was first performed. Operations were performed using a variety of models of Harmonic scalpel and without vaginal tubes or delineators
Results
49 patients underwent Total Laparoscopic Hysterectomy with a mean age of 40 years. 55% (27/49) of patients has had previous surgery for endometriosis 37%. (18/49) of patients had had a previous Caesarean section. The mean hospital stay was 3.6 days with a range of 2–8 days The mean operating time was 109 minutes (81 minutes for women without endometriosis). 19 patients had additional procedures (9 radical resections of endometriosis, 1 ileostomy, 11 salpingoophrectomy, 2 laparoscopic anterior resections). There was one bladder perforation and one vesicovaginal fistula in a patient who had had a partial cystectomy for deep bladder endometriosis. There was one instance of trauma to the inferior epigastric artery. The mean drop in haemoglobin was from 1.7 g% and a mean estimated blood loss of 165 ml. 26/49 patients had a drain. 14 (29%) of hysterectomy specimens had histological adenomyosis and 8 (16%) had fibroids.
Conclusions
Total laparoscopic hysterectomy is a safe alternative to total abdominal hysterectomy and may readily be combined with radical surgery for severe endometriosis.

TOPIC 4: HYSTEROSCOPY

P034

The Role Of Hysteroscopy In Infertile Patients. A Clinical Study

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The use of hysteroscopy is not generalized in the assessment and treatment of infertile patients. We present our recent experience, and evaluate its' role in this cases.
Material and methods: During 15 months (October 2004-December 2005), there were 110 hysteroscopies performed, and from them 52 were in cases with infertility, as a unique or associated indication (47%). The procedures ranged from simple diagnostic to adhesion resection, polyp removal, myomectomy. The data were analyzed with standard statistic functions.
Results: The average age of our patients was 32.6 (CI95± 1.2). The main diagnostic was: inferiltity (44%), amenorrhea (5%), menorrhagia (7%), synecchiae (33%). The hysteroscopic description of the endometrium was: normal (67%), atrophic (13.5%) and hypertrophic (19.5%). Other lesions seen at hysteroscopy were: polyps (23%), inflammation (10%), fibroids (10%) and uterine septum (4%). The tubal ostium were also assessed, as normal (67%), unilateral (23%) or bilateral obstruction (10%). Besides simple diagnostic, we performed surgical gestures in 50% of cases consisting of polyp removal (13%), uterine adhesion resection (36%) and fibroid resection (4%).
In conclusion, we consider hysteroscopy an important tool for the evaluation of infertile patients, and therefore recommend it for a large use in this gynecologic specialty.

P035

Myomectomy during pregnancy-a case report

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Uterine leiomyomas are by far the most common benign tumours of the female genital tract. The true incidence of leiomyomas during pregnancy is, however, unknown. Although leiomyomas usually remain asymptomatic dur-

ing pregnancy, they may complicate its course. The management of leiomyoma during pregnancy is medical, but in rare circumstances surgical intervention and myomectomy may be required. A case of myomectomy in early pregnancy is described.
Keywords: leiomyoma; myomectomy; pregnancy

P036

Hysterosocopic removal of Intra-uterine Disorders: a comparison of the Intra Uterine Morcellator to conventional resectoscopy

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Objective: The purpose of this RCT is to compare the learning curve of residents in training for both techniques.
Methods: The hysteroscopic morcellator is a device similar to an arthroscopic surgery blade inserted into a 9 mm hysteroscope. The major advantages are: the use of saline solution instead of the electrolyte-free solutions used in monopolar high-frequency resectoscopy and the ease of removal of the tissue fragments through the instrument. Sixty patients with polyps or submucous myomas type 0 were recruited and randomized after informed consent. Patients were treated by residents with the new hysteroscopic morcellator or with conventional resectoscopy.
Results: Primary outcome measures were the assessment of the ease of use and performance measured by operating time, fluid deficit, number of instrumentation insertions and subjective surgeon satisfaction scores. Secondary outcome measures were complications in terms of perforations, bleeding and TUR-syndrome. The results of this study will be presented. Conclusion: The new technique of hysteroscopic morcellation for the removal of endometrial polyps and submucous myomas may offer a safe and effective alternative to conventional resectoscopy with a shorter learning curve as it seems easier to perform. Additionally, the implementation of hysteroscopic surgery into daily gynecological practice, which is a matter of concern, may accelerate with this newly introduced technique.

P037

Endometrial adenocarcinoma, diagnosis in hysteroscopy consult

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Objective: The main target of this study was to evaluate the probability of presenting endometrial adenocarcinoma in patients who went to the hysteroscopy consultation of our hospital.
Design & Methods: From May to December, 2005 there were made a total of 885 hysteroscopies with biopsy, using micro-clamps or micro-scissors, and histopathology study. We had 470 pre-menopause patients (153 with metrorrhagia and 317 asymptomatic), and 415 post-menopause patients (259 with metrorrhagia and 156 asymptomatic).
Results: 2.3% of the total of the patients were diagnosticated of endometrial adenocarcinoma. In menopause group the probability of presenting endometrial adenocarcinoma was elevated to 6.2%, but if the patient also presented metrorrhagia the risk was elevated to 9.3%. Nevertheless the incidence of carcinoma in asymptomatic menopausal women was of the 1.2%. In non-menopausal women the probability of presented an endometrial adenocarcinoma, is low, 0.6%, that is increased to 1.9% if the woman presents metrorrhagia. We have not found any carcinoma in asymptomatic in non-menopausal women. Additionally, we study a correlation between the diagnosis by hysteroscopy and histopathology; the sensitivity of the test was 95%.
Conclusion: i) The probability of having endometrial carcinoma in menopause patients with metrorrhagia is greater than in non-menopause women, ii) in asymptomatic non-menopausal women the probability of have endometrial adenocarcinoma is null, and iii) the hysteroscopic image has a diagnosis sensitivity of 95%.

P038

Versapoint: diagnosis and treatment of polyps in the same surgical act. evaluation of eficacy

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Objective: To evaluate polyps resection using ambulatory bipolar surgery (Versapoint®), and to compare the cost of this ambulatory surgery vs. Traditional programmed surgery.
Design & Methods: In our hysteroscopy consult during 5 years, where resected 2240 endometrial polyps with versapoint®. This procedure was carried out in ambulatory setting, without anesthesia or analgesia. Once finished the surgical time the patients went out and allowed to made their daily activities as soon as they want.
Results: Using versapoint® we resected in ambulatory setting 90% of all the polyps (n=2016), whereas the use of micro-scissors had allowed to only cut out 60% (n=1344). Therefore this data indicates that 672 women did not underwent surgical intervention, and this supposes 134 polyps per year. If we calculate at a reason of 6 ambulatory polyps resection for day, this suppose a saving of 23 days of operating room per year. The cost of the process is in consulting room 279 € opposed to 449 € in operating room. The daily amount is divided by the following way: (i) *Operating room:* personal 147 €, reanimation personal 139 €, expendable equipment 63 €, instrumental 48 €, preanesthesia 52 €. Total: 449 €. (ii) *Consulting room:*

Personal 24 €, reanimation personal 0 €, expendable equipment 23 €, Instrumental amortization 24 €, pre-anesthesia €. Total: 279 €.
Therefore the saving in 5 years is of 114.240 €.
Conclusions: Using Versapoint®, at the same surgical act it is possible to see and treat in a fast and safe way and to reduce the number of resections in operating room (30% more polyps are resected using Versapoint®). With respect to economy Versapoint® supposes a saving of 35% when compared to conventional surgery.

P039

Abulatory hysteroscopic treatment of endometrial polyps

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Objectives: The main aims were: i) To analyze symtoms of consultation and hormonal stage (pre-menopause or post-menopause) in patients with endometrial polyps, and ii) to describe the different methods for removing endometrial polyps diagnosed in our Hysteroscopic Unit during 2005.
Design & methods: Retrospective study of 412 cases of endometrial polyps diagnosed in hysteroscopy setting during 2005. The instrument used were: a Bettocchi's™ hysteroscopic (5 mm), bipolar electrode (Versapoint®) and mechanic element (micro-scissors and micro-clamps).
Results: 412 polyps were diagnosed, 45% occurred in post-menopause patients and 55% in pre-menopause.
The first cause of consultation was metrorrhagia (50.7%), followed by echographic indication in absence of sinto-mathology (43.3%), treatment with tamoxifeno (1.40%), hyperplasia control (1.4%) and suspicion of endometrial carcinoma (0.20%). The types of polyps detected were: hyperplasic glandular polyp (88%), complex polyp (2%), atypical hyperplasic polyp (0.5%), carcinoma on a polyp (0.5%) and atrophic polyp (9%).
Ninety one per cent of polyps were removed by ambulatory hysteroscopy, using versapoint® in 77%, micro-scissors in 19% and laser in 4%; only a 9% of the polyps needed surgical hysteroscopy.
Conclusion: Thanks to the use of versapoint® more than 90% of endometrial polyps diagnosed can be removed in ambulatory setting.

P040

Patients attending ambulatory hysteroscopy: reason related to hormonal stage

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Objective: To value the reason why patients go to the hysteroscopy consultation and the diagnostic performed by hormonal stage.
Design & Methods: We analize 1203 patients that went to hysteroscopy consultation of our hospital (from January to December 2005). The patients were divided in two groups: menopausal non-menopausal women. Hysteroscopy was performed with a Bettocchi´s™ hysteroscopy (5 mm), without speculum, anesthesia or Pozzi´s clamps.
Results: The most frequent cause of consultation was metrorrhagia (66.4%), followed by echographic indication in asymptomatic women (14.6%). In the group of non-menopausal women the most frequent pathology was functional endometrium (38.4%), followed by endometrial polyp (28.5%), atrophic endometrium (19%) and with smaller percentage endometrial hyperplasia, myoma and carcinoma. In the group of menopausal women, the most frequent pathology was endometrial polyp (44.9%), followed by atrophic endometrium (36.6%), carcinoma (6.2%), functional endometrium (5%), endometrial hyperplasia (3.5%) and myoma (3.3%).
Conclusions: i) Metrorrhagia is the most frequent reason for consultation in patients, ii) the endometrial polyp is the most prevalence pathology in menopausal women, and iii) functional alterations of endometrium are the pathology more frequently found in non-menopausal women.

P041

Improvement of reproductive outcome and menstrual pattern after hysteroscopic polypectomy in previous Infertile women with Symptomatic Endometrial Polyps.

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Objective: To evaluate the reproductive benefits of hysteroscopic polypectomy in previous infertile woman with menstrual disorders and no other risk factors for infertility.
Methods: From April 2001 to November 2004, 42 selected women with diagnoses of primary or secondary infertility and abnormal uterine bleeding who underwent transvaginal ultrasound, diagnostic hysteroscopy because of indicative findings for endometrial lesion in ultrasound and hysteroscopic polypectomy. All 42 subjects who were included in the study, met inclusion criteria: age under 35 years, at least 12 months of infertility and from 3 to 8 months menstrual disorders (intermenstrual bleeding, menometrorrhagia or menorrhagia). Follow-up period was from 6 to 15 months after hysteroscopic polypectomy with attempts to conceive spontaneously. The endometrial polyp/polyps appeared to be the only reason to explain their infertility after infertility work up of the couple that was performed preoperatively.
Results: Of the 42 subjects, 41 were found to have endometrial polyps in diagnostic hysteroscopy, confirmed at histologic examination. Among the study group of

patients, there were no significant differences in age, length of infertility, or follow-up period after the procedure. Primary infertility had 24 patients and secondary infertility had 18 patients. Following polypectomy menstrual pattern was normalized in 95.2% of patients. Spontaneous pregnancy and live birth rates were increased after the procedure and were 58.5% and 43.9% respectively. The majority of pregnancies were achieved in the first year after the procedure (in 75% of the study group). Spontaneous abortion rate in the first trimester of pregnancy was 14.6%. Complication rate after hysteroscopic polypectomy was low 2.3% (one case with moderate uterine bleeding postoperatively).
Conclusion: Hysteroscopic polypectomy of symptomatic endometrial polyps appeared to improve fertility in previous infertile women with no other reason which explains their infertility. Type of infertility (primary or secondary) seem not to affect fertility rates after hysteroscopic polypectomy. Pregnancy rate after hysteroscopic polypectomy was 58.5%, live birth rate was 43.9% and menstrual pattern was normalized in a percentage over 95% of patients. In addition, hysteroscopic polypectomy is a safe procedure with low complication rate.

P042

Three years experience with Versapoint system

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Introduction: The aim of this study was to evaluate our experience with versapoint (Johnson & Johnson) in endometrial pathology.
Methods: We used a 5,5 mm Olympus operative hysteroscope and versapoint system with bipolar electrode (springle, twizle).
350 procedures with bipolar electrode in normal saline dispersion fluid were performed between 2003 and 2005.
results: The commonest pathology treated was the polyps: 273 cases (78%)
In 56 patients (16%) were excised submucous myomas and in 21 patients (6%) other pathologies were treated.
In two patients we had uterine perforation treated conservatively.
Discussion: Versapoint system with bipolar electrode consents to the endoscopic gynaecologist to perform many operative procedures without significant patient discomfort, with very excellent results.

P043

The efficiency of hysteroscopy in diagnostics of endometrial and miometrial pathology

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Objectives. To evaluate the efficiency of operative hysteroscopy in diagnostics of endometrial and miometrial pathology.
Methods. All hysteroscopies performed at the Gynecological Department at year 2005 were analyzed. Preoperative reason for operation was taken into account. Intraoperative findings and histological results from operative material were compared with the initial data.
Results. 304 hysteroscopies were performed at the Gynecological Department in 2005. 256 (84%) hysteroscopies were performed because of suspected by ultrasound endometrial pathology (A group), 43 (14%)-because of miometral pathology (B group) and 5 (2%)-diagnostic (C group). In group A diagnosis of endometrial pathology (polyposis, endometrial hyperplasia or endometrial cancer) was confirmed in 249 (97%) cases and only in 7 (3%) cases submucosal myoma was diagnosed. In group B 38 cases (88%) of submucosal myoma and 2 (5%) cases of endometrial polyp were diagnosed. Also 3 (7%) cases of sarcoma were found in this group. In C group only in 1 case endometrial polyp was observed and other 4 cases were without a visible endometrial pathology.
Conclusions. Hysteroscopy has a very high confirmation rate of suspected endometrial or miometral pathology. Unexpected findings can also be found. The final diagnosis can be done only after a histological examination.

P044

Hysteroscopy as an advantage in the treatment of Uterine Bleeding

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Introduction. Operative hysteroscopy (resectoscopy) is effective as a conservative surgery treatment of uterine bleeding caused by the benignant endometrial changes (i.e. endometrial hyperplasia and polyps, submusocal myomas, retented IUD etc.).
Methods. All patients we have treated since the beginning of 2006 were in reproductive or (peri)menopausal age and they were bad responders on the conventional therapy of metrorrhagia, i.e. D&C, uterotonics, HRT etc. All histological findings showed benignant endometrial changes in the range of functional thickness to complex hyperplasia. All patients were preoperatively underwent to bimanual pelvic examination, colposcopy, Pap-test, microbiological cervical smear and transvaginal color-doppler ultrasound. In all patients we used the Richard Wolf GmbH operative hysterosocope (resectoscope) of 25,5 Fr. diameter with 4 mm telescope and monopolar electrodes fit through the operating channel. Loop electrode was more convenient for larger tissue structures when it was necessary histological verification, but cutting and coagulating electrodes were more suitable for the other intrauterine manipulations as well as the exact haemostasis.

Results. Despite of the short experience for a while, our results are mostly favourable. Considering the observed parameters, estimated therapeutic benefits has been achieved, i.e. sucessfully treating the symptoms and improving the general condition of the patients. According to standard methods, results were statistically significant, but we have to include much more patients for the accurate analyzis.
Discussion. In patients with benignant endometrial changes hysteroscopy showed a lot of advantages as the alternative of hysterectomy. The procedure is safe, visually guidied and painless with minimal cervical dilatation, brief duration, no need of general anesthesia and short hospitalization. Namely, patients has been dismissed next day after the treatment, which is a real criteria of the "one-day surgery". So, we shall strongly support new approaches in advanced hysteroscopy, i.e. bipolar technology we planning to accept as soon as possible.

P045

Pyometra treated by Cervico-Isthmic resection
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Objective: Case report, review of the literature and discussion
Design and methods: A 67 old woman had pyometra diagnosed on a uterine collection and severe inflammatory syndrome. The collection persisted after a first treatment (drainage and antibiotics). Hysteroscopy was then performed with cervico-isthmic resection and the patient recovered.
Result: Clinical significance of recurrence of pyometra is discussed considering the published data.
Conclusion: Pyometra may be associated with malignancy; endoscopic approach is efficient for diagnosis allowing tissue sampling, and for treatment by performing better cervical drainage.

P046

Uterine Sarcoidosis: An Infrequent Lesion Discovered By An Endometrial Resection
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Objectives: Case report and review of the literature.
Methods: A 46 old Para 3 African woman underwent endometrial resection for menorrhagia
Results: Histology revealed non caseating giant-cell granulomatas with Schauman's bodies in the endometium and the myometrium. A few cases have already been reported and are discussed.
Conclusion: Genital sarcoidosis is a very uncommon condition; diagnosis must include search for other systemic lesions.

P047

Hysteroscopic surgery: a safe and efficient procedure. A review of 330 personal cases
R. Garnier
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Objectives: Retrospective analysis of a continuous series and discussion in regard of the litterature.
Design and methods: From 1989 to 2006, 330 hyseroscopic surgical procedures have been performed by a single surgeon in a private practice. Indications included 108 submucosal fibroids, 119 endometrial resections, 74 polyps, 10 synechiae,10 uterine septa.
Results: 2 perforations and 2 T.U.R. syndromes were observed; discussion will point out the conditions of a safe procedure. Results in different indications will be discussed and compared to the litterature.
Conclusions: Hysteroscopic surgery can be performed easily with safety and efficiency when a small number of rules are observed.

P048

The role of hysteroscopy after failed typical diagnostic curettage
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Aim: The aim of this study is to evaluate the role of hysteroscopy in cases with unsuccessful dilatation of internal cervical os.
Method: We examined 25 women between 60–80 years old who underwent diagnostic curettage. In all cases dilatation of cervical canal was not possible. Hysteroscopy was performed in 16 cases at the same time and in 9 cases in a second time. We started with attachment of surgical hysteroscope to the cervical canal and we find the internal cervical os which is deviated due to myomas, adhesions, superflexion etc. The verification of closed canal is done with the easy passage of 5Fr forceps. In12 cases surgical hysteroscopy is performed with a 2.9 Karl Storz endoscope with a final diameter of 5 mm, examination of endometrial cavity and finally biopsies are taken. In 13 cases in which insertion of surgical hysteroscope is not possible we use the 2 mm diagnostic hysteroscope with the inner sheath of final 3.8 diameter. We continue with the bigger sheath of 4.3 mm so we perform an increasing dilatation. Finally easier insertion of 5 mm surgical hysteroscope is performed. In 5 cases biopsies from the whole uterine cavity was found to be necessary so we perform dilatation with Hegar dilatators and we proceed to diagnostic curettage.
Results: Hysteroscopy is found to be the initial assessment for any type of indication requiring uterine cavity examination avoiding blind methods.

P049

The role of hysteroscopy in treating patients with uterine myomas Difficulties in hysteroscopic myomectomy

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Aim: The aim of this study was to evaluate the difficulties of hysteroscopic myomectomy and also the safety and efficacy of resectoscopic myomectomy.
Methods: We examined 55 patients between 26–67 years old with uterine myomas who treated with hysteroscopic myomectomy.
In 34 cases, with myomas till 3 cm we used Versapoint without difficulties.
In 21 cases with myomas between 3–4 cm resectoscopic myomectomy was performed.In 3 cases resection was not possible because of an intense uterine contraction and a subsequent bad visualisation.In these cases we performed dilatation with Hegar dilatators till No 12,the exact place of myoma was found and then a polyp forceps was used to remove the remaining parts of myoma. Examination of the whole cavity and coagulation was performed. In 1 case hemorrhage was still continued. We used a Folley catheter, filled with 3 cc Normal saline and we left it for 2 days in the uterine cavity, so hemorrhage stopped.
Results: All myomas are resected according to their size either with Versapoint or with resectoscope. When problems occur, because of intense and persistent contraction, operation can be completed with dilatation of cervical canal and grasping the myoma with forceps from its known place.

P050

Endoscopic diagnosis of Mullerian Anormalities: functional endometrium in no communicating rudymentary horn

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We present several cases of severe dysmenorrhea in patients diagnosed of unicorn uterus with no comunicant rudimentary horn presenting functional endometrium. We discused how the diagnosis was made, aided with endoscopic thecniques (hysteroscopy and laparoscopy), and how it was resolved.

P051

A method forsafe hysteroscopic synechiolysis operationsin patients with Asherman's syndrome

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Introduction: Asherman's syndrome is characterized by the presence of intrauterine adhesions that typically result from scar formation after uterine surgery, especially after repetitive dilatation and curettage (D&C) and hysteroscopic surgery. We present a case of Asherman's syndrome after hysteroscopic myomectomy and the hysteroscopic treatment.
Methods: A case report
Results: A 32-year-old woman, gravida 2 para 0, presented with hypermenorrhea and atypical genital bleeding. She was diagnosed with a submucosal myoma and polycystic ovary syndrome (PCOS). Hysteroscopic myomectomy and laparoscopic laser vaporization for PCOS were performed on September 7, 2005. Amenorrhea lasted for 55 days after the operation. Although estrogenic and progesteronic drugs were administered by injection and orally for 21 days, withdrawal bleeding did not occur. Asherman's syndrome was suspected and hysteroscopic synechiolysis was performed on January 22, 2006. We performed mechanical synechiolysis with hysteroresectscopy around the uterine cervix and uterine body using transrectal and transabdominal ultrasonographies, respectively, to guide the direction of its approach without electrosugery. To prevent intrauterine re-adhesion, the patient was given an intrauterine contraceptive device for one month and oral estrogenic and progesteronic drugs for two months, which resulted in withdrawal bleeding and menstruation. Diagnostic hysteroscopy was performed on April 13, 2006. Only minor adhesions were observed especially around the fundus in the uterine cavity and the contraceptive treatment was stopped.
Discussion: Asherman's syndrome occurs after hysteroscopic myomectomy because intrauterine adhesions form as a wound healing mechanism before endometrium regeneration due to PCOS in which the formation of functional endometrium is slow. Of the hysteroscopic surgeries, synechiolysis has the highest risk of uterine perforation. We propose a safe hysteroscopic method using mechanical synechiolysis without electrosurgery.

P052

Placental polyp: an unusual hysteroscopic finding

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Introduction:
Placental polyps are pedunculated chorionic or placental fragments, which are retained in the uterine cavity after an incomplete abortion or term pregnancy. They appear usually as highly vascular, irregular intrauterine masses; their etiology is still unclear.
Abnormal uterine bleeding in a woman of childbearing age may be the sign of a placental polyp, particularly if she was recently pregnant.

Case report:
The authors present the case of a 30-year-old woman, who had undergone an abortion for medical reasons in 28/12/06 (the fetus presented an omphalocele). In February 2006 she was sent to our hospital with persistent metrorrhagia since then. The transvaginal echography associated with saline-infusion hysterossonography showed a heterogeneous, sessile, intracavitary mass, with over 30 mm of diameter. The patient was submitted to hysteroscopic ressection in 02/03/06; the histologic finding revealed placental polyp.

P053

Uterine septus: fertility and obstetrical outcome after hysteroscopic section of uterine septus

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Introduction: uterus septus is the most frequent congenital uterine anomalies caused by insufficient resorption of the mullerian ducts. It is well recognized that it increases the incidence of recurrent miscarriages, reprodutive failure and obstetric complications. The combined use of laparoscopy and hysteroscopy is the gold standard for diagnosis.
Objective: the aim of this review was to assess fertility outcome and obstetrical outcome of 6 patients one year after hysteroscopic section of uterine septa.
Materials and Methods: retrospective study about 6 patients consulting for septate uterus and repeated pregnancy loss or infertility. Septal lysis was performed with microscissors or resectoscope between november 2004 and may 2005. one with primary fertility, four with recurrent miscarriages, and one with late abortion and secondary infertility.
Results: 6 cases were reviewed. The mean age at diagnosis was 31. The diagnosis of septate uterus was suspected by ultrasound and sonohysterography and confirmed by laparoscopy and hysteroscopy. All cases were submitted to endoscopic resection of uterine septus. The anatomical result was considered satisfatory in all cases and in all has been performed a second look All dissections of the septum occurred without complications. After the ressection 5 patients were interested in pregnancy. One became pregnant in the follow up period of one year, and is still pregnant with 30 weeks of gestation
Discussion: Hysteroscopic treatment of uterine septa is a safe and simple procedure. According to literature it improves obstetrical prognosis of patients presenting repeated pregnancy loss and septate uterus. After hysteroscopic treatment 1/5 (20%) became pregnant. The short follow up period (one year) can explain the low rate of pregnancies observed. we think that endoscopic ressection of uterine septus should be undertaken whenever a uterine septum is diagnosed and if the women wants to became pregnant. The patients should be awared of a non imediate obstetrical outcome.

P054

Hysteroscopic Myomectomy as a method of choice: long term results in 150 patients

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Objective: Main objective was to assess the efficacy of the method, hysteroscopic myomectomy, depending on the size and type of the submucous fibroids.
Materials and Methods: The study was designed as retrospective. We have followed-up 150 patients submitted at our Clinic between January 2000 and December 2003, with submucous fibroids diagnosed by trans-vaginal ultrasonography at outpatient bases that underwent first a diagnostic hysteroscopy and after that hysteroscopic resection of the fibroids. The selection for the treatment was made according to the type and especially the size of the fibroids. The main indications were the abnormal uterine bleeding (menorrhagia and metrorrhagia) and in several cases fertility problems. Forty-nine percent of women were perimenopausal.
Results: Eighty percent of the patients were followed up to 30 months (median interval) after surgery (range min. 18–50 max. months). The treatment was successful in 95 percent of the patients. In 5% of the cases procedure was unsuccessful (3 patients with type II fibroides and size>35 mm had repeated procedure and other 3 with recurrence of symptoms). There was no major intra operative complications and the minor complications were rare (1, 2%).
Conclusion: The hysteroscopic myomectomy is a method of choice for treatment of submucous fibroids. It is safe and effective long-term therapy for carefully selected women with abnormal uterine bleeding and infertility.
Keywords: hysteroscopic resection, submucous fibroid.

P055

Long-term follow up of hysteroscopic myomectomies

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Objectives: Retrospective study of histopathological diagnosis and the most frequent complications of hysteroscopic myomectomies.
Design & methods: Retrospective analysis of the data included in a data base Epi-info, related to the hysteroscopic myomectomies performed by the authors between 1997 and 2005. All the procedures were performed employing an Olympus hysteroscope 26 fr and an Olympus hystero-flow.

Complications included:

–Metrorragia: in case of profuse bleeding that made the placement of a Foley catheter endocavitary necessary. No second surgical procedure was needed in any of these cases.
–Cervical laceration (if suture needed)
–Uterine perforation: This includes those due to mechanical action (the most frequent) and those produced by diathermy.
–Glicine loss if greater than 1500 cc.

Results: 188 hysteroscopic myomectomies were studied. The preoperative diagnosis included 156 myomas and 32 polyps. No complications occurred in 155 cases (82,4%). Minor complications included 14 cases of haemorrhage that needed a Foley catheter to be controlled, 5 cases of cervical laceration that needed suture, 3 uterine perforations and 11 cases of glicine loss greater than 1500 cc. None of them carried out long-term complications. Patient satisfaction was excellent or good in 78%. Histopathology showed 175 leiomyomas, 8 fibrous polyps, 2 leiomyosarcomas and 3 polyps and myoma.
Conclusions: Hysteroscopic myomectomy is a safe procedure, with less than 20% of complications and none of them severe.
Out-patient hysteroscopic diagnosis of submucous myomas offers a great fiability.

P056

Why is it recommendable to resect all endometrial polyps?

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Objectives: To evaluate the findings and results in hysteroscopies performed to resect endometrial polyps in our Minimally Invasive Surgery Unit.
Design & methods: 187 polypectomies performed between February 1999 and December 2005 in the out-patient unit of our department, using a continous-flow hysteroscope STORZ (Bettochi) with saline solution. Histopathology, complications and, when possible, a control hysteroscopy or endovaginal ultrasonography was registered 3 to 6 months after extirpation.
Results: Neither intraoperatory nor postoperatory complications occurred in these series. Histopathology showed 142 benign polyps, 13 hyperplastic polyps, 6 glandular hyperplasias, 1 atypical hyperplasia, 6 myomas, 6 secretory endometrium, 1 papilar adenocarcinoma and 3 endometrial adenocarcinoma.
3 to 6 months later, in 107 cases symptons had dissappeared and control hysteroscopy or ultrasonography was normal, not having the control yet in 61 cases. 2 patients were lost and other 3 had a LAVH made because of benign processes. In 6 cases, the findings were sinechiae and in 3, the polyp persisted. The four patients with endometrial adenocarcinoma had a hysterectomy made. 1 patient was pregnant at the time of surgery (unnoticed) but pregnancy went on without complications.
Conclusions: Although routine endometrial polyp resection is under discussion, specially those small and asymptomatic, we enhance other units to perform it as complications are rare, the technique is simple and easy and allows the physician to have the hystopathology. Moreover, nowadays with the new continous-flow hysteroscopes , the complications are exceptional. In our setting, 4 cases of endometrial adenocarcinoma and 1 of atypical hyperplasia were detected.

P057

Submucous myomas: when to purpose outpatient hysteroscopic myomectomy

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Objective: The aim was to identify selection criteria of submucous myomas that can be treated by hysteroscopy in outpatient setting.
Design & Methods: Retrospective and comparative study of 48 women less than 45 years old, who had been submitted to outpatient hysteroscopic myomectomy of submucous myomas, from 2001 to 2005. A saline distension and a bipolar 5 Fr electrode VersaPoint® were used. Reintervention was considered as a repeat procedure at any time, in cases of clinical or ultrasonographyc evidence of incomplete resection. We compared two groups: Group I-women who needed more than one intervention (n=22); Group II-those treated in one session (n=26). The parameters analysed were: type of the myoma (type 2 *vs* types 0 or 1, according to Wamsteker classification), largest diameter and number of myomas. The statistical significance of the differences between groups was obtained with Student's *t* test and the Fisher exact test. Multivariable analysis was performed using a binary logistic regression model. All *p* values less than 0.05 were considered significant.
Results: Mean age 37,5±5,8 years old; 27% (n=13) nulliparous; follow-up 18,7 months (min.3, max.26); number of procedures 1,54 (between 1 and 3); tolerability 5,4±2,1 (pain scale 1 to 10). Women with type 2 myomas had a significantly higher need for reintervention (71,4% *vs* 28,6%; p=0,03). Regarding the two groups considered, there were no significant differences in terms of: duration of procedure (59±30 *vs* 55±25 minutes; p=0,7), the presence of a single myoma (40% *vs* 60%, p=0,58) or a myoma diameter greater than or equal to 3 cm (63,6% *vs* 36,7%, p=0,16). Myomectomy of type 2 myomas was independently associated with an increased risk of reintervention, regardless of the number and size of the tumor (OR 4,5; 95% CI 1,2–17,3; p=0,028).
Conclusions: Although safe, outpatient hysteroscopic myomectomy of submucous myomas type 2 was associated with a high rate of reintervention. A previous careful

classification of the submucous myomas is the most important selection criteria for a successful outpatient resection.

TOPIC 5: PERINATAL MEDICINE, FETOSCOPY AND INTRAUTERINE FETAL SURGERY

P058

Laparoscopic surgery for ovarian tumors during 2nd trimester pregnancy in comparison with laparotomy

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Objectives Laparoscopic surgery had been considered to be contraindication because the hydro carbonated oxygen gas with high intra-peritoneal pressure may cause acidosis of fetus during operation. In 1991, laparoscopic appendectomy and cholecystectomy during pregnancy were first reported and so far more laparoscopic gynecologic surgeries were done bringing lots of benefits to patients. This is a report on the outcomes of laparoscopic surgery for ovarian tumors during pregnancy in comparison with laparotomy. We also report our tips for safe laparoscopic surgery during 2nd trimester pregnancy.
Methods The postoperative course and pregnancy outcome of 29 patients who underwent laparotomy for ovarian tumors during pregnancy were compared with those patients who had laparoscopic surgery. Surgery was indicated in cases with an ovarian tumor which was not diagnosed as a lutein cyst and with possibility to subsequently cause torsion or arrest of labor. Laparoscopic surgery was done during 16 to 19 weeks of gestational age in cases the tumor with diameter of more than five centimeters which did not have features of malignancy by sonography or tumor makers. Laparoscopic surgery was performed with caution not to raise the intra-peritoneal carbon oxide pressure over 15 mmHg in to avoid acidosis of mothers and fetuses using a Lap Disc Mini, a wall-sealing device, for safe insertion of the first port or an open technique (Hasson). We also use bipolar coagulation for accurate hemostasis.
Results There were no significantly difference in backgrounds of patients between patients who underwent laparoscopic surgery and laparotomy. The period of hospitalization was significantly shorter in patients underwent laparoscopy than patients with laparotomy (p; 0.05). The average duration of operation in laparoscopic surgeries was significantly longer than that of laparotomies (p; 0.05). There was no difference of the average dose of ritodrine hydrochloride and antibiotics medicated during hospitalization in these two groups.
Among the 29 patients who underwent laparotomy, four patients needed hospitalization due to threatened premature delivery. There were two premature deliveries because of IUGR and PIH. Among the seven patients who underwent laparoscopy, one patient needed hospitalization due to threatened premature delivery. There was no significant difference in the rate of threatened premature delivery and premature delivery.
Discussion Laparoscopic surgery during pregnancy is a safe procedure if it performed in an appropriate manner. Pregnant patients can be applied to the advantages of minimally invasive surgery, such as shorter hospitalization, earlier ambulation and oral intake, smaller wound and less pain. The most important thing is accurate assessment of ovarian tumors before laparoscopy. We have to make an image inspecting ovarian tumors and enlarged uterus precisely and decide the position of the ports.

P059

More cases of increased fetal nuchal translucency and their embryoscopic imaging.

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Transcervical embryoscopy is a procedure during which the fetal characteristics, in terms of anatomy, development and correlation with the surrounding tissues, can be efficiently studied. A series of 10 fetuses presenting an ultrasound with increased nuchal translucency were studied with the use of modern instruments (1.7 mm hysteroscope). It seems that transcervical embryoscopy is able to distinguish the fine anatomic anomalies that are related to genetic syndromes, already recognized via ultrasonography. Thus, our established opinion that embryoscopy may help the diagnostic process by verifying the initial findings is hereby verified once again. To the same direction, embryoscopy may contribute in recognizing anomalies that may have already led to death in-utero2. It is, however, imperative to perform further studies investigating embryoscopy's efficiency and contribution to the prenatal diagnostic process.

TOPIC 6: REPRODUCTIVE SURGERY

P060

Assisted reproduction treatment results after pretreatment operations on account of different gynecological pathology

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Objective: The aim of this work was analysis of assisted reproductive treatment (ART) results after pretreatment operations on account of different gynecological pathology.
Design & Methods: We had analyzed data of 81 women with (mean age 34,7 years) in 81 ART cycles (without separation routine IVF, IVF-ICSI, frozen/thawed and eggs donation programs) after pre-ART treatment with hysteroscopy including simultaneously hysteroscopy/laparoscopy (SHL) because of cavity pathology and hydrosalpinx. Everybody has unsuccessfully ART treatment attempt/s before due to different gynecological conditions. Endoscopic equipment manufactured by Karl Storz. The main study design was to start ART treatment after hysteroscopy (or SHL) in the same menstrual cycle (MC). The long midluteal protocol were started in the same with operation/s menstrual cycle with depo a-GnRH and rFSH (Gonal-F, Serono) was used for controlled ovarian hyperstimulation. The midluteal depo a-GnRH was taken in the same with operation MC in frozen/thawed attempts hormonal replacement preparing of endometrium (Divigel, Orion Pharma) as for recipients was used. Luteal support 50 mg of oil injection of progesterone and 300 mg micronized progesterone vaginally.
Results: Surprisingly, but the overall clinical pregnancy rates was 60.49%. Separately for pathology: polypectomy 17 from 20 (PR 85%); endometrial hyperplasia 14 from 23 (PR 60.87%); septectomy or semiseptectomy 13 from 28 (PR 46.43%); combined polypectomy/semiseptectomy 5 from 7 (71.43%); adhesiolysis 0 from 3 (PR 0%).
Conclusions: Thus we have quite enough data to speculate that period between operation and starting ART must be as short as possible.

P061

Polygynax after hysteroscopy before assisted reproduction treatment.

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Objective: The aim of this work was the analysis of postoperative periods course by the example of infections and fever before assisted reproductive treatment (ART) after hysteroscopy on account of uterine cavity pathologies.
Design & Methods: We had analyzed data of 197 women with (mean age 33.1 years). Indications for operations were unsuccessfully ART attempt/s before due to different gynecological conditions. Among cavity pathology distinguished: endometrial polyp/s, endometrial hyperplasia, uterus arcuatus, uterus septata, uterus semiseptata, T-shaped cavity, stage 0-I myoma, endometriosis, different stage of Asherman`s syndrome. Hysteroscopy was performed in midfollicular phase. Everypatients were taken Polygynax (Laboratoire Innotech International, France) vaginally one suppository daily during 12 days after operations starting from the same day or from the day before. The main study design was to start ART after operation/s in the same menstrual cycle. In the 81 cases we have had finished ART attempts (women with mean age 34,7 years) (without separation routine IVF, IVF-ICSI, frozen/thawed and eggs donation programs) after pre-ART treatment with hysteroscopy including simultaneously hysteroscopy/laparoscopy (SHL) because of cavity and non inflammatory pelvic pathology. Endoscopic equipment manufactured by Karl Storz. The long midluteal protocol were started in the same with operation/s menstrual cycle with depo a-GnRH and rFSH (Gonal-F, Serono) was used for controlled ovarian hyperstimulation. The midluteal depo a-GnRH was taken in the same with operation MC in frozen/thawed attempts hormonal replacement preparing of endometrium (Divigel, Orion Pharma) as for recipients was used. Standart luteal support was taken.
Results: We have registered just 7 cases of subfebrile body temperature during first 24 hours after operations so our strategy are enable to prevent considered complications. Furthermore, the overall clinical pregnancy rates in finished ART attempts was 60.49%. Separately for pathology: polypectomy 17 from 20 (PR 85%); endometrial hyperplasia 14 from 23 (PR 60.87%); septectomy or semiseptectomy 13 from 28 (PR 46.43%); combined polypectomy/semiseptectomy 5 from 7 (71.43%); adhesiolysis 0 from 3 (PR 0%). Conclusions: No considered complications after hysteroscopy with Polygynax taking on the one hand with possibilities of prompt starting ART after operation/s in the same menstrual cycle on the other hand present enough data to speculate that our strategy are reasonable.

P062

Long-term prognosis in women with ectopic pregnancy in the only tube.

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Objective: To evaluate fertility rate after the reconstructive surgery in women with ectopic pregnancy in the only fallopian tube.
Methods: First group consisted of thirty five women with ectopic pregnancy who hadn't surgeries earlier. Thirty five patients of ages 20 to 36 years old with ectopic pregnancy in the only tube were included in the second group. Patients of the second group underwent salpingectomy for ectopic pregnancy during previous 3 years. In our study all the patients were treated in the stage of progressive ectopic pregnancy. Beta-human chorionic gonadotropin levels measurement and ultrasound investigation were used as preoperative diagnostic methods. The diagnosis of ectopic pregnancy was confirmed by laparoscopy. Tubotomy, "milking" and adhesiolysis were performed.

Results: The predictive positive value of preoperative diagnosis was 95.3%. The cumulative intrauterine pregnancy rate in 12 months was significantly higher in the first group (54, 6%) than in the second (42, 3%) (Log rank $P<0.05$) after the treatment. In 24 months there were no significant differences between the women with two or one tubes. Pregnancy rate 64, 7% in women of the first group and 59, 9% in women with the only tube.
Conclusions: The results of our study showed that treatment of women with ectopic pregnancy in the only tube could be as successful as treatment of patients with two tubes. It's important to use the modern advanced treatment strategy for reducing time from initially reporting the symptoms to a physician and surgery time. It allows performing tubotomy and increasing the fertility rate.

P063

Laparoscopic treatment of 'Sub-hepatic 'Ectopic pregnancy in a fallopian tube of a non communicating rudimentary uterine Horn

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Introduction: Ectopic Pregnancy in a non communicating rudimentary uterine horn is a rare occurance.The authors described a case of Ectopic pregnancy in a fallopian tube of a non communicating uterine horn. The unusually high position of the Ectopic gestation into sub hepatic region affects the early clinical presentation
Methods: A case report of nulliparous who presented in atypical clinical picture of ectopic pregnancy in term of localisation of the pain.It was mainly in right hypochondrial region. Diagnostic laparoscopy was carried out.
Findings: A unicornuate uterus with normal Left fallopian tube and ovary. there was a right rudimentary uterine horn, which was displaced laterally and was adherent to the lateral abdominal wall. There was a thin elongated tubular band of tissue, connecting this horn to the uterus. Also, an elongated tube starting from this rudimentary horn, extending upwards, adherent to the abdominal wall, ends a few (3–4) cm below the lower edge of the right lobe of the liver. At the distal end of this distorted tube, was an ectopic pregnancy, in close proximity with the lower edge of the right lobe of the liver.
Results: Laparoscopic Right salpingectomy was performed with bipolar diathermy and scissors. Histology confirmed interspersed chorionic villi in the lumen of the fallopian tube. Patient had uneventful recovery.
Conclusion: The authors described a rare case of a tubal pregnancy in a non communicating rudimentary uterine horn. Firstly, the pregnancy was in the tube connected to the rudimentary horn, secondly the abnormally high position of the rudimentary horn with its tube and thirdly the long convoluted fallopian tube with its sub hepatic position. Successful laparoscopic salpingectomy can be carried out.

P064

Surgical management of Ectopic Pregnancy. Why so few laparoscopies? Experience from a Large District Hospital. Northwest UK

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Despite that minimum standard for surgical management of ectopic pregnancy is considered 70% of cases to be managed laparoscopicaly; in large district hospital (4000 deliveries per year) this practice is still difficult to achieve. The poster includes recent retrospective audit results from 5/10/2003 to 25/12/2005; 70 ectopics have been treated surgically: 29 (42%) of them laparoscopicaly and 41 (58 %) with laparotomy; all 70 with salpingectomy.
This poster explains the reasons why fewer laparoscopic procedures have been undertaken. (Training issues, lack of instruments, time restriction and experienced operator availability for laparoscopic surgery). The poster gives information about fertility rates after salpingectomy, operative complications and postoperative follow up.
Laparoscopic treatment with experienced operator has a lot of advantages for the care of the patient. The recent evidence about laparoscopic use for ectopic pregnancy has difficulties to be applied and implemented correctly in district hospitals. Collaboration with specialised units in minimal access surgery and further validated training is mandatory.

P065

A simple and effective laparoscopic technique for reversal of sterilisation in women

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Introduction: We report our results of a simple laparoscopic technique of tubal reanastomosis, which was first described by Barjot in 1999.
Materials and methods: From September 2002 through November 2005 we performed laparoscopic tubal reanastomosis in 36 patients. We started with a diagnostic laparoscopy, then hysteroscopically catheterised the proximal tubes and guided the catheter further into the distal tube. Approximation of the mesosalpinx was performed with one stitch Vicryl 4/0 and consequently two stitches with Vicryl 4/0 were placed at the site of the anastomosis through the serosa and muscularis. At the end of the procedure the catheters were removed. This technique was used in patients 1 and 2 and from patient 16 through 36 (group 1). However, in patients 3 through 15 we only put one stitch through the serosa and muscularis at 12 'o clock and closed the serosa with Tissucol, a fibrin tissue adhesive. In these patients we also left the catheter in place for 5 to 7 days (group 2).

Results: The average age of our patients was 35,8 y (range 24–44). The average operating time was 137 minutes (range 80–260). There was one patient who did not have the desire to become pregnant and there were 4 patients loss-to-follow-up (LFU). The total pregnancy rate (TPR) was 48,4% (15/31 patients). The total intra-uterine pregnancy rate was 41,9%. The total pregnancy rate in group 1 (18 patients) was 72,2% versus 15,4% in group 2 (13 patients). When we split the patients from group 1 according to age, we have a total pregnancy rate of 91,7% in patients younger than 38 versus 33,3% in patients 38 years and older.
Discussion: There is a significant difference in total pregnancy rate (TPR) between group 1 and group 2. This is probably related to the difference in technique, however all of the patients of group 2 belonged to the first 15 patients of our experience, so the influence of the learning curve might be as important as that of the operative technique. The TPR in the group of patients younger than 38 is 91,7%, which shows that this technique is highly effective. This operative technique is simple and necessitates only regular laparoscopic material. It should be first choice in young women desiring a child after sterilisation.
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The TPR in the group of patients younger than 38 is 91,7%, which shows that this technique is highly effective. It should be first choice in young women desiring a child after sterilisation.
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P066

Second-look after laparoscopic myomectomy in infertile patients: is it useful? Our preliminary data.

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Introduction: To evaluate fertility and pregnancy outcome after laparoscopic myomectomy and to assess adhesion rate and other postoperative complications at second look laparoscopy.
Method(s): Prospective study.Setting in University Department.
Ninety patients aged between 18–42 years, with infertility>24 months and fibroids, as unique cause of primary or secondary infertility, were enrolled. Of these 62 patients underwent second look laparoscopy.
We assessed: Pregnancy rate according to patient, fibroid characteristics and second-look endoscopy.
Result(s): Forty-five patients became pregnant (50%). The mean (±SD) age was 35.1 years. Of 46 pregnancies, 37 women delivered a singleton fetus and 1 twins (42.2% birth rate). The pregnancy rate was significantly higher in women<35 years of age. Significant difference was noted in pregnancy rate concerning fibroid characteristic. Twenty-eight (45%) of 62 patients that underwent at second look conceived, and of this group 25 (89%) were found to have a pelvic pathology.
Conclusion(s): The age influences the fertility and pregnancy. Adhesions post-myomectomy can interfere with the fertility. The chance of conception in infertile patients could be re-established diagnosing and treating complication post-myomectomy.

P067

Laparoscopic and hysteroscopic myomectomy, clinical outcome of 145 cases

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Objective: Uterine leiomyomas are clinically apparent in up to 25% of women. The influence of myomas on reproduction has been clearly demonstrated as myoma presence was associated with decreased pregnancy rates. The incidence of myomas in infertile women without any obvious case of infertility is estimated to be under 10%. Analysing the database of infertile patients underwent treatment by assisted reproductive techniques in our Institute from 2002 to 2006 resulted an incidence of 9% of uterine leiomyomas without any other cause of infertility. The location of the myoma plays an important factor, with submucosus, intramural and subserosal fibroids being in decreasing order of importance, in causing infertility. The size of the myomas represent another important prognostic factor, 2–3 cm in diameter being the size limit which appears to justify myomectomy with the purpose to improve fertility. In our series we included a few patients, like a 53 years lady desireing egg donation and pregnancy not readily included in these kind of studies. It has been proved by many clinical trials that surgical management of myomas improves pregnancy rates in assisted reproductive cycles. Results from randomized trials have shown that when pregnancy is desired, the laparoscopic technique of myomectomy in the hands of a skilled surgeon appears particularly advantegous in that it could reduce the risk of postoperative adhesions, provides the advantage of less blood loss during the surgical procedure, faster recovery, lower postoperative pain and shorter hospitalization compaired with laparotomy. In several. uncontrolled surgical trials, restoration of fertility after myomectomy has been reported, with pregnancy rates ranging between 44 and 62%. The aim of our presentation is to show the results of our retrospective study evaluating previous laparotomies, length of infertility, size, location, number of

myomas, surgical time, age, blood loss, hospitalization, number of conversion to laparotomy, reoperations, transfusions after laparoscopic myomectomy in 145 patients.
Design & methods: The objective of our study was to evaluate our results of laparoscopic myomectomy. Laparoscopic myomectomy has been performed in our Department from January 2003 to December 2005 at 145 patients who had at least 1 either subserosus or intramural or intramural with submucosal component myoma minimum 20 mm.
Results: There were 78 cases that have previous operations. There were 110 infertile patients, with 1–30 years length of infertility. The number of removed myomas per patient varied from 1–8 and the size of the myomas were between 20–120 mm. The uterine wall was sutured either in one or two planes depending on the depths of the myometral defect. The surgical time varied from 30–120 min and the blood loss was between 50–300 mL. Age of the patients varied between 25–55 years. Time of hospitalization was between 24–168 hours, mean 92 hours. Converting to laparotomy was needed in 3 cases, and we reoperatied one patient. There was need for transfusion in only one case when the preoperative Hb level was 92 and the anesthetist required the transfusion during the operation.
Conclusions: Advances in surgical instruments and techniques are expanding the role of laparoscopic myomectomy. Laparoscopic myomectomy is a safe procedure with minimal invasive approach and provides a preferable alternative to abdominal myomectomy for women who have myomas and try to avoid hysterectomy or have infertility primarily related to fibroids.

P068

The diagnosis and treatment of heterotopic pregnancy

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Introduction: The natural occurrence of heterotopic pregnancy (HP) has been estimated at 1 out of 30000 of all spontaneous pregnancies Diagnosis is often difficult because HP in more than a half could be asymptomatic. This condition may lead to increased maternal morbidity. The aim of this study is to describe diagnosis and treatment of (HP).
Methods: Seven cases refered to our hospital between January 1999 and February 2006. Heterotopic pregancy was clearly identified in three cases. In four patients HP was asymptomatic. In five cases viable intrauterine pregnancy was visualisated before the treatment. Every patient was treated surigically but only two of them laparoscopically. Six patient underwent salpingectomy and one salpingotomy. Intrauterine pregnancy outcome were recorded.
Results: In every case postoperative period was uneventfull. Three subsequent ongoing alive intrauterine pregnancies were delivered at therm and one is an ongoing pregnancy at 15 weeks. In patient were salpingotomy was performed the intrauterine pregnancy misscaried within 3 weeks of surgery.
Discussion: Heterotopic pregnancy is very rare. The diagnosis of this condition is difficult. Surigical treatment provide good outcome and salpingectomy seems to be more safely for intrauterine pregnancy.

P069

Laparoscopic tubal anastomoses: three stitch suture technique

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Advances in endoscopic surgical technique have allowed skilled endoscopic surgeons to perform tubal anastomoses by laparoscopy reporting similar results than laparotomy. Classic microsurgical technique includes single stitch suture in mesosalpinx, 4 stitch of suture in muscle layer, then serous layer is approximated with 3–4 stitch suture. This technique is discussed because of the difficulty in the suturing technique by laparoscopy.
Our objective is to evaluate the outcome of tubal patency and pregnancy rates using three stitch suture technique.
Methods: We retrospectively evaluated 5 women who were referred for laparoscopic tubal reanastomosis.
We used the three stitch suture in seromuscular layer (12, 4, 8 o'clock sutures) using a 6-0 Vicryl, preceded by an approaching stitch suture in the mesosalpinx under the tube, using a 4-0 Vicryl. Koh laparoscopic microsurgical instrument were used. All patients had preoperative hysterosalpingography confirming sterilization.
Results: the mean age was 35.8 (range 26–40). Tubal sterilizations were carried out by Pomeroy technique in 4 cases and in one case by Yoon Ring. 80 % (8/10) of tubes were reanastomosed, and in 2 cases tubal repair was achieved in only one tube, because of an inadequate distal tube segment. Pregnancy rates was 40% (2/5). Pregnancies were achieved by patients who had bilateral reanastomosis and were younger (26 and 36 years). Six months after surgery, non pregnant patients (37, 40, 40 years) have undergone hysterosalpingography to evaluate postoperative tubal patency and it was demonstrated in 100% of the operated tubes. The mean operative time was 150 minutes (range 140–160).
Laparoscopic tubal reanastomosis is as efficient as laparotomy. The simplified three stitch technique is easier and effective reporting pregnancies rates and tubal patency similar than others published techniques. More patients are necessary to evaluate this simplified technique.
The age of the patients is one more time a predictor factor of pregnancy rate.

P070

Fertility Parameters After Laparoscopic Surgery for Distal Tubal Disease

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Objective: To assess the significance of some laparoscopic morphologic criteria for distal tubal disease and to determinate the influence from their implementation on postoperative fertility parameters.
Materials and methods: The study was designed as prospective. We have included 300 patients submitted at our Clinic over four year's period, with diagnosed distal tubal disease that was treated by laparoscopic reconstruction. Excluding criteria for the study was subnormal sperm gram of patient's partners, according to WHO criteria. During the surgery each patient was adequately staged according to the staging system by the French authors, irrespectively of the joined adhesions. The main follow-up parameters were cumulative rate of conception and cumulative probability for conception.
Results: Mild and moderate deterioration of ampullary morphology (stage1 and 2) were registered in 32 (10,67%) and 108 (36%) patients, respectively. On the other hand, the higher stages (3 and 4) were registered in 40 (13,33 %) and 120 (40%) patients, respectively. Cumulative conception rates were 64%, 47%, 15% and 4,2% in four groups, respectively with statistically significant differences ($p<0,01$) in first two groups. The curves of cumulative probability for conception reached the plato at the 18-th month of follow-up, with analogical statistical differences.
Conclusion: The condition of the tubal ampula is the crucial and most important predictive factor for successful conception and should be considered as main element during the treatment, follow-up and consulting of the patients with distal tubal disease but also the influence of the other factors like (male factor, age, duration of infertility) should not be overlooked. Good tubal morphology (stage 1 and 2) with at list minimal passage of the contrast (fimosis), gives a real chance for natural conception after certain postoperative period. In the cases of deteriorated tubal morphology (stage 3 and 4) mostly associated with true hydrosalpings, cumulative rates of intrauterine pregnancy are extremely low and salpingectomy (or proximal occlusion) should be considered as a preparation and main condition for optimal IVF results, which is a method of choice for treatment of infertility in this subgroup of patients with distal tubal disease.
Keywords: distal tubal disease, laparoscopy.

P071

Does Endometriotic Cystectomy affect ovarian reserve? FSH value

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Introduction: to evaluate whether endometrioma surgery could reduce ovarian reserve and its effect on ART outcomes.
Methods: Thirty-two women previous submitted to surgery for endometrioma were selected and compared with 59 patients who did not. B-FSH levels and pregnancies of these groups were compared.
Results: b-FSH in the endometrioma group was significantly higher than in those patients who had no surgery for endometriotic cyst (8.5±4.7 *vs* 6.5±3 mIU/ml respectively) ($P<0.05$). Clinical pregnancy rates were similar (9.4% vs 11.9%), although the direction was toward improved pregnancy rates in the group of patients without history of ovarian surgery.
Discussion: In our experience, although the history of endometriomas seems not to affect IVF/ICSI pregnancy rate results, excision of endometriomas is associated with a reduction in ovarian reserve. Couples should be informed that lower oocytes numbers would result in reduced, but still encouraging, pregnancy rates if the age is young.

P072

Laparoscopic conservative management of unruptured interstitial ectopic pregnancy

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

Conclusions: Laparoscopic conservative treatment of unruptured ectopic pregnancy is possible in selected cases. Advanced minimally invasive surgical experience is required.
A single dose of methotrexate is preferably given in order to minimize the risk of persistent ectopic pregnancy.

TOPIC 7: UROGYNECOLOGY

P073

Three Novel "Tension Free" Techniques to Cure Vaginal Vault Prolapse: IVS post., TOT post. and TVM post.

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Objective: this study was carried out to compare perineal ultrasonographic (US) findings and assess the efficacy of three different procedures named "tension free": (A), IVS posterior; (B), TOT posterior and (C), TVM (Tension free Vaginal Mesh) in the management of patients with vaginal vault prolapse.
Design & Methods: 16 patients, 12 after vaginal and 4 after abdominal hysterectomy with ≥ stage II cuff prolapse, who required surgical treatment, pre-operative evaluation included: history, urine culture, pelvic examination, US imaging of pelvic floor, urodynamics. At regional anesthesia, 9 (A), patients underwent IVS post., 4 (B), with TOT post. and 3 (C), by TVM approach. All techniques provides apical as well as posterior vaginal wall support. Outcomes measures intra-operative complications, clinical prolapse degree, US evaluation of the bladder neck, apex of the vagina, anterior rectal wall, the tape or mesh position and width, healing abnormalities, dyspareunia, at last follow up after 1,3,6 and 12 months.
Results: the mean patient age was 65 (range 43–83 years), mean parity was 3 (range 2–6). At last follow up visit, vaginal vault prolapse was restored in all patients, granulation reaction to the mesh occurred in 1 patient after TVM, no tape or mesh ejection was found, no dyspareunia was reported. US examination showed in all patients, no significant differences in the tape or mesh position among three surgical procedures.
Conclusions: US helps us to understand the pathology of an individual patient and to analyze precisely anatomical outcome of three surgical procedures to cure vaginal vault prolapse.

P074

Follow-up of procedures carried out using various types of graft to correct pelvic floor disorders in our region

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Introduction: Over a 20-month period, a series of procedures were carried out in this hospital, in order to assess the characteristics of the devices used to adapt these to our area, and to assess results in these patients.
Objective: To assess the results of various techniques with which we have experience. To undertake exhaustive follow-up in order to detect any complications that may possibly arise. To report on our limited experience of the various methods.
Material and methods: We have collated the results of surgery performed in order to correct pelvic floor disorders in 74 women, using a graft. The indication for anterior/middle or posterior correction was evaluated on the basis of a clinical assessment of the various defects in the different compartments. Use in association with incontinence techniques was based on the urodynamics performed in women with severe prolapse (grade II or more), thus detecting urinary stress incontinence concealed by the prolapse. Graft techniques were also used in association with vaginal hysterectomies as a means of preventing a prolapse in severe cases and young women. Follow-up was undertaken in the first week, after a month, 3, 6 and 12 months, and then annually with the intention of continuing up to 5 years.
Results: Incontinence techniques were performed in association with these procedures, using transobturator devices: Monarc in 11 cases (14.9%),TVTO in 2 cases (2.7%), Kelly in 2 cases (2.7%). Techniques to correct the anterior/middle compartment: Perigee in 29 cases (39.2%), Prolift in 9 cases (12.2%), Avaulta in 3 cases (4.1%), anterioroplasty in 4 cases (4.7%). Techniques used to correct the middle/posterior compartment: Apogee in 18 cases (24.7%), Prolift 4 cases (5.4%), PelviLace 9 cases (12.2%), Avaulta 3 cases (4.1%), posterior IVS 6 cases (8.1%), Bridge 1 case (1.4%), posterior plasty 3 cases (4.05%). Intra-operative complications were reported in 5 cases (6.8%); vesical lesions in 3 cases (4.05%), obstruction in 1 case (1.35%), haemorrhage in 3 cases (4.05%), haematomas in 3 cases (4.05%), infection in 1 case (1.35%). The most serious was a retroperineal haematoma requiring a laparotomy. This was not related to the graft insertion procedure, but to the vaginal hysterectomy performed before the device was fitted.

P075

Results of transobturator sling for urinary stress incontinence

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Objective: The aim of this study was to analise the results of transobturator sling for stress incontinence in our unit.
Material and Methods: We report on 120 patients controlled in our unit, all of whom were suffering from pure stress incontinence, confirmed by a urodynamic study and ultrasonography. Between March 2004 and December 2005, patients have been operated in our hospital, using the technique of the suburethral sling with transobturator approach isolated or combinated with other pelvic surgeries. The final assesment was made in our own unit including exploration and quality of life questionnaire.
Results: From all the 120 patients evaluated, 92,3% did not present stress incontinence, with no cases of complication, such as bladder perforation or haematomas.
Conclusions: The transobturator sling is a useful technique for the tratment of female urinary stress incontinence due to its good results, low rate of complications and simplicity.

TOPIC 8: OTHER

P076

Sonohysterography-sensitivity and specificity for endometrial pathology

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Introduction Sonohysterography is a safe, low-cost and minimally invasive technique, which permits the visualization of the uterine cavity, by using a sterile saline solution.
Objectives To evaluate the sensibility and sensitivity of sonohysterography in diagnosing endometrial pathology.
Material and Methods A retrospective study of all sonohysterography studies followed by hysteroscopy with ressectoscopy and pathological examination between July 2003 and June 2005 was performed. The sonohysterographic diagnosis was compared with the pathological result.
Results One hundred and twenty-seven sonohysterography were evaluated and 107 polyps, 10 leiomyomas and 10 endometrial thickness were found.
Sensitivity and specificity were:

- Polyps (S) 94,8%; (Sp) 32,6%
- Leiomyomas (S) 56,3%; (Sp) 96,4%
- Endometrial thickness (S) 42,9%, (Sp) 94,2%

Conclusion Sonohysterography is a reliable technique for diagnosing endometrial polyps but not for leiomyoma or endometrial thickening.

P077

The villous mucinous Cystadenom of Appendix in a postmenopausal woman diagnosed and treated with laparascopy

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A cystic lesion in the right adnexal region was detected by vaginal sonography in an otherwise healthy woman with no symptoms at the age of 64. The postmenopausal patient was gravid 0 and had no previously performed gynaecological operations and had no pain.
Vaginal Sonography:
Ultrasound showed a dumbbell cystic structure with a diameter of 70×22 mm with regular wall without any infiltration.
MR of Pelvis:
A dumbbell cystic structure with liquid content in right pelvis with no penetration of the wall and with a liquid content. No definitive connection to the ovary or tuba uterine. The lesion is ventral of the iliacal bifurcation.
No malignancy signs.
Tumour markers
There was an elevation of Ca-125 to 71,7 and TPS of 91,7
Therapy:
A diagnostic Pelviskopie was performed to evaluate the localisation and the dignity of the cystic lesion:
Uterus both adnexa with no pathology. The lesion was actually a distended Appendix with a rugged consistence. A Pelviskopie appendectomy was performed and the Appendix could be removed totally in endotouch.
Histology:
Villous mucinous Cystadenom of Appendix with low grade intraepithelial neoplasia.
Discussion:
The villous mucinous Cystadenom of Appendix is a very rare disease and hard to diagnose through imagination methods. When there is a suspicion, then a diagnostic Pelviskopie with AE should be performed.

P078

Laparoscopic treatment of interstitial pregnancy

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Introduction: To evaluate the laparoscopic surgery technique which allows to control blood loss and avoid laparotomy and hysterectomy.
Methods: Two cases of laparoscopic cornual resection for interstitial pregnancy are described.
Results: To prevent massive blood loss during laparoscopy it is important to have access to uterus vessels. It is possible to provide such an access by making a hole in the broad uterus ligament on both sides. A hole was made, so the uterus vessels on both sides were visualized and thus

prepared for coagulation in case of hemorrhage. To decrease blood loss, the distal part of the uterus artery was coagulated by bipolar electric current followed by additional suturing of the uterus wall below gestational sac localization. After that, interstitial pregnancy was cut out with scissors in both cases. The uterus wall was restored by two layers of Vicryl sutures. The surgery duration was 210 and 215 minutes. Blood loss at surgeries was 450 ml and 500 ml. There was no need for blood transfusion. The postsurgery hospital stay was 4 and 2 days.
Discussion: Interstitial pregnancy is a rare type of ectopic pregnancy, comprising up to 2–4% of all the ectopic gestational sac localizations. At present, interstitial pregnancy is most often treated by either laparotomic resection or methotrexate application. Both of these methods have disadvantages. Laparotomy is accompanied by adhesions development and long postsurgery hospital stay. Methotrexate therapy is potentially dangerous as it can lead to side effects and, making it worse, persistence of chorionic tissue is possible.
Laparoscopy does not have these drawbacks. But during laparoscopy it can be difficult to control bleeding. To decrease blood loss, the distal part of the uterus artery is coagulated by bipolar electric current followed by additional suturing of the uterus wall below gestational sac localization. This technique allows for laparoscopic resection of unrupted interstitial pregnancy and effective control of bleeding, thus making it feasible to avoid transition to laparotomy and hysterectomy.

P079

Minimally invasive interventions for treatment of pelvic floor pathology

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The objective of the study was to evaluate the efficacy of minimally invasive interventions for pelvic floor pathology. 75 female patients aged from 30 to 83 years were evaluated.
Materials and methods. The above patients were divided into 3 groups. Group 1 included 29 patients with genital prolapse. Group 2 included 19 patients who had a combination of genital prolapse and another pathology. Group 3 included 28 patients who had genital prolapse and urinary stress incontinence. The combination pathology included evident rectocelle, cystocelle, adhesive disease of the peritoneum, scarred changes in the paraurtharal areas, evident somatic pathology, diabetes mellitus, hypertension, etc. In group 1, the following interventions were performed: total vaginal hysterectomy (29 interventions), anterior and posterior colporaphy with levatoroplasty (26), laparoscopic sacropexy with the use of propelene mesh (2), vaginopexy with GyneMeshSoft (5), vaginopexy with the use of Prolift total (1). In group 2, 2 laparoscopic adhesiolyses, 3 laparotomies, 4 LAVH, 10 vaginal total hysterectomies, 15 anterior and posterior colporaphy with levatoroplasty, 2 laparoscopic sacropexies with the use of propelene mesh, 1 laparoscopic vaginal ventrofixation, 1 laparotomic vaginal ventrofixation with mesh, 1 vaginopexy with GyneMeshSoft, 2 herniaplasties were performed. In group 3, 3 TVTs, 20 TOTs, 1 Burch procedure, 4 laparoscopic paraurethral viginopexies, 1 total vaginal hysterectomy and colporaphy were performed.
Results. Postoperative follow-up was from 4 months to 2 years. In group 1, there were no recurrencies. There were 2 cases of acute cystitis. In group 2, there were neither complications nor recurrencies. In group 3, 2 patients had unsatisfactory effect after laparoscopic Burch procedure. Both patients underwent TVT obturator with good results.
Conclusions. In treatment for genital prolapse, the intervention of choice is total vaginal hysterectomy with reconstruction of the pelvic floor. In treatment for urinary stress incontinence the surgery of choice is TVT obturator.

P080

Risks of laparoscopic surgery and new technological developments

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This poster critically evaluates recent evidence about operative risks with laparoscopy,
Discuss whether new technological developments alter these risks and benefit of the interventions.
Summarise in an algorithm possible operative risks.
Point out the difficulty to get clear evidence about:
The rates of intra-operative complications or post operative complications.
The immediate and intermediate complications (such as, fluid overload or injury to gastrointestinal or urinary tract) and later consequence of operative surgery (such as post site herniation or post side disease).
Innovations in laparoscopic surgery need to be critically analysed comparing evidence versus personal operating comfort and cost.
Use of technological advances may lead to safer and successful treatment. Continuous information about successful treatments and complications is necessary in order to improve our skills.

P081

Alexithymia and quality of life in gynaecological surgery

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Background: Most studies evaluating quality of life after surgical or medical treatment made use of questionnaires which considered the subjective perception of life quality. Nonetheless, only few studies took into consideration the variability introduced by personality factors, regardless of the fact that the description and perception of life quality might be deeply affected by the personality construct and might lead to a remarkable difference in the evaluation of surgical therapy outcome. The effect of laparoscopic and laparotomic surgeries for gynaecological pathologies has been well documented, but little is known on the influence of the patient's personality factors on the outcome of surgery and quality of life of the patient. In order to verify the influence of the personality trait in the evaluation of life quality, we analysed the effect of alexithymia on the outcome of gynaecological surgery. Alexithymia is reported (Sifneos, 1973) to be a disorder of the regulatory mechanism of emotion elaboration. This psychic construct identifies a group of affective and cognitive characteristics observed in patients with psychosomatic diseases, presenting disturbances of affect regulation linked to failure in psychological self-regulation and deficit in experiencing emotional life. The purpose of the present study was to investigate the prevalence of alexithymia by using Toronto Alexithymia Scale-20 (TAS-20) and to examine the relationship between alexithymia and self-reported descriptors of quality of life in gynaecological population.
Methods: 40 consecutive patients (mean age 50 years), suffering from a benign gynaecological pathology, were enrolled in the study; twenty of them underwent laparoscopy and twenty laparotomy. All patients were evaluated in a semi-structured interview in which personal, medical and social data were collected. They were provided with a set of questionnaires that included both measure of alexithymia (TAS-20) and quality of life perception (The Medical Outcomes Study short-form general health survey-36, known as the SF-36). The patients were assessed before the surgical procedure and 1 month post-operatively.
Results: gynaecological patients were separated in two groups, with respect to the TAS questionnaire score: the high-level alexithymia group (HA), with scores above 61, and the low-level alexithymia group (LA), with scores below 51. We observed significant statistical differences between LA and HA in each surgical group. Our data reveals that the subjective QoL tested with SF36 in gynaecological patients undergoing surgery is clearly influenced by the level of alexithymia.

P082

Injury of the abdominal aorta during laparoscopic surgery: Is it worth palpating the aorta prior to the procedure?

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Background: Injury to major retro-peritoneal vessels is the most catastrophic complication of closed laparoscopy. Injury is most likely when the aortic bifurcation is caudal to the umbilicus. Knowledge of the site of the aortic bifurcation prior to inserting the umbilical port would be expected to reduce the risk of this type of injury. We wanted to determine the feasibility of identifying the aortic bifurcation by palpation.
Patient and methods: We studied 100 consecutive women undergoing laparoscopic surgery or laparotomy. After prepping and draping, the operating surgeon felt for the aortic bifurcation to determine its position in relation to the umbilicus. We then related our findings to the height, weight and body-mass index (BMI) of the patient.
Results: The average age of the 100 women was 36.9 (SD 7.9) years. All but two were listed for laparoscopy. The mean height and weight of the group was 162.3 (SD 7.0) cm and 64.9 (SD 13.1) kg respectively. The body-mass index (BMI) ranged from 16.9 to 39.8 with a mean of 24.7 (SD 4.9); 6 women were underweight (BMI<18.5), 57 had a normal BMI (18.5–24.9), 23 were overweight (BMI 25.0–29.9), and 14 were clinically obese (BMI≥30.0).
The aorta could not palpated in 15% of cases, including almost 2/3rd of women who were obese. In the remaining 85 cases where the aorta was palpable, the bifurcation was above the level of the umbilicus in 30 (35%) cases, at the umbilicus in 45 (53%), and below in 10 (12%). We didn't find any statistically significant relationship between the position of the aortic bifurcation in relation to the umbilicus and BMI, weight or height. No vascular injury occurred in the laparoscopic cases during the study.
Discussion: The aortic bifurcation can be palpated in the majority of women who are not obese. Awareness of the position of the aorta means the angle of insertion of the Veress needle and the primary port can be modified, and a shallower entry angle utilized in cases where the bifurcation is relatively caudal. Although a much larger study would be required to prove that routine palpation for the aorta at the start of laparoscopy would reduce the risk of aortic injury, it is a simple procedure which adds little to the overall set-up time, and seems a sensible precaution. We believe it should be standard practice in all cases of closed laparoscopy utilizing subumbilical entry.
Conclusions: Closed laparoscopic entry is associated with a low but definite risk of major vascular injury to the retroperitoneal vessels. We recommend the routine palpation for the aortic bifurcation as a possible means of reducing this risk.

P083

Digital video recording of surgical procedures using a personal computer

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Introduction The visual recording of surgical procedures either as still images or movies is becoming standard practice across many specialities. Analogue recording using film or video is gradually being replaced by digital technology for reasons of quality and convenience. Commercial systems are available but are expensive and have limited capabilities and capacity. We describe a video capture system built around a stand-alone personal computer which is considerably cheaper and yet significantly more versatile.
Methods We built the system around a modern personal computer with a large hard disk to allow recording of over 250 hours of surgery. Digital capture from the camera was achieved using a standard external analogue-digital converter linked to the computer via a firewire cable. The software for capturing, compressing and editing movie files were obtained free of charge from the internet.
Findings We have successfully used this system to record over 500 major and minor gynaecological procedures. Recordings could be played back using standard and freely available computer software such as Windows® Media Player which comes free with the Windows® operating system for PC's. Despite compression, the quality of the movies was good and still images excellent. The recordings could be integrated in to presentation software such as Microsoft® PowerPoint. Still pictures could be printed to provide hard copies for patients and medical notes, and movies burnt on to CD's using free software such as Windows® Media Player.
Conclusion A digital recording system built around a standard personal computer is relatively cheap, versatile and has a huge capacity to record surgical procedures.

P084

Laparoscopic management of a very large ovarian cyst-implications for the patient

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A 21 year old lady presented with abdominal pain and distention and she was found to have a massive ovarian cyst. A scoring system for possible malignancy revealed the index to be low on the basis of imaging and Ca125. The cyst was drained pre-operatively (1.25 L) prior to a laparoscopic ovarian cystectomy, where a further 1.5 L were drained. Discussion includes advantages and disadvantages of the operative route along with implications for future fertility.

P085

Uterine malformation with corpus agenesis. A case report.

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[Introduction] Incomplete fusion of the Mullerian ducts results in various degrees of division of the uterine cavity. Congenital absence of the uterus is an uncommon abnormality usually associated with anomalies of the sex chromosomes, as exemplified by the testicular ferminization syndrome. Moreover absence of the uterine corpus rarely occurs in women with a normal chromosomal pattern. To date, only very few cases of solitary congenital absence of the uterine corpus have been reported in the literature.
[A case] We encountered uterine malformation with corpus agenesis in a 16-year-old chromosomally competent Japanese woman who presented with a history of primary amenorrhea. She had normal antenatal and delivery histories, and her secondary sexual characteristics began to develop when she was 11 years old. Physical examination revealed a well-developed female with normal external genitalia. She had a 46XX karyotype. Her sex hormones-follicular stimulating hormone, luteinising hormone, progesterone, and oestrogen-were all a within normal limits. Withdrawal genital bleeding did not occur though she had gotten a hormonal injection. On uterine cavity sounding, the cervical canal ended blindly with a length of 2 to 3 cm. Biopsied specimen obtained from curettage showed that there was no endometrial tissue. Laparoscopy examination revealed the right fallopian tube and cervix but no uterine corpus or left adnex. Based on these findings, it was clear that this was a case of solitary absence of uterine corpus in a chromosomally-competent woman.
[Discussion] This case was presented as class 1-C in the classification of Mullerian anomalies published by the American Fertility Society in 1988. Probably because no treatment is available for the class 1-C anomalies and because of its extremely low incidence, they are seldom mentioned in the literature. Laparoscopic examination will be the best examination for investigation of uterine malformation when patients want to know their physical condition.

P086

The use of a proforma improves the documentation of hysteroscopies

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Objective: To determine whether the clinical information recorded improves and meets required standards using a proforma for hysteroscopic procedures.
Methods: The case notes of thirty women that underwent a hysteroscopy from eight consultant theatre lists were analysed three month after the introduction of a hysteroscopic record form. The general information recorded

included patient detail, indications, management plan, surgeon's signature as well as the operation findings in particular vaginal examination findings, uterine findings, use of a diagram or photo. The findings were compared with the data collected from a baseline audit carried out to ascertain the level of clinical information recorded at hysteroscopy. One of their recommendations was to introduce a more formalised method of data collection as records were found to be of poor standard.
Results: The use of a structured record form for hysteroscopic procedures led to a more accurate and complete documentation of relevant information. The information recorded using the proforma improved for vulval findings from 44% to 100%, for cervical findings from 67% to 95% and uterine findings from 92% to 100%.
The recording of other standards using the proforma was consistently high, including patient details, indication, management plan, surgeon's name and signature, vaginal examination, specimen for histology. Additional hand written text was used in 85% of cases and a diagram, photo or both was used in 58% of cases.
Conclusions: The introduction of a hysteroscopy proforma has improved the quality of operation notes significantly. Comprehensive and meticulous documentation aids communication, is an integral part of high quality care and aids to reduce liability. Therefore the use of a structured record form can be recommended.

P087

Improving Spillage Rate During Laparoscopic Management Of Ovarian Teratoma

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Introduction: This study to describes a surgical technique effective to minimize cystic spillage in the laparoscopic management of ovarian teratoma. A retrospective study with a review of cases of women with dermoid cysts who underwent cystectomy or annessectomy by laparoscopy.
Methods: Between January 1998 and May 2006 136 women with a diagnosis of dermoid cysts by ultrasound required surgical management. Of these, 128 women with benign cysts underwent laparoscopic cystectomy and 8 underwent annessectomy for other reasons.
Laparoscopic technique was standardised. The ovary was grasped on the antemesenteric border. The ovarian cortex was lifted from the cyst to facilitate identification of the cleavage plane. A small incision was made (1–1,5 cm) and was extended in depth with sharp and blunt dissection was to establish the correct plane taking care to avoid rupture of the cyst "Four wheel drive technique".
Results: Using this method a small number of ruptures occurred. In fact spillage was observed in 16 cysts (12%). In the spillage group no chemical peritonitis occurred. The mean size of dermoid cysts was 5.1 cm (range 1.5–15 cm) and no significant intra-operative blood loss occurred during laparoscopic ovarian cystectomy. The mean operation time was 40 minutes (range 25–100).
Discussion: This laparoscopic surgical technique of ovarian cystectomy should be considered as a valid method for the removal of benign ovarian cystic teratomas. It offers minimal spillage of cysts with consequent reduction in postoperative adhesions, reduced pain and shorter hospital stay.

P088

The contribution of laparoscopy in the evaluation of abnormal abdominal pain in young women.

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AIM: Recurrent abdominal pain is a common symptom in young girls that may be caused by gynecological problems. This study evaluates retrospectively the preoperative work-up and the operative treatment of abdominal pain in young girls at our institution. METHODS: During 1990–1995 analyzed the authors in this retrospective study the charts of 120 adolescent girls,who hospitalized for acute lower abdominal pain. The age of the patients ranged from 13 to 25 years. All patients had undergone laparoscopy for investigation and subsequent therapy of ultrasonographically and gynecologicaly examination. RESULTS: Twenty eight procedures were only diagnostic, while the rest 92 were additionally operative. Seventy-two (60%) of all operations were emergency procedures; of these, 55 had functional ovarian cysts, eight patients were operated on for an adnexal torsion and nine patients had other adnexal conditions. Unilateral salpingo-oophorectomy was performed on 2 patients, unilateral oophorectomy on 4 patients, ovariancyst resection on 49 patients and ovariancystcoagulation on 17patients. In the rest of patients we had founded, in 32 (26.67%) of cases pelvic inflammatory disease, in 3 (2.5%) benigne ovarian tumors, in 2 (1,6%) of cases, ectopic pregnancy in 0.33% of cases, paraovarian cyst in 11(5%) of cases and endometriosis in 2(1,6%) of cases. We had no complications. High awareness and timely laparoscopy contributed to conservation of the adnexa in our young patient. CONCLUSION A gynecological examination with sonography should be included in the diagnostic work-up of a young girl's abdominal complaints. With a proper preoperative work-up adequate treatment, which often consists of expectation, can be chosen for the patient and subsequent problems related to fertility and abdominal complaints can be avoided. The laparoscopic management of the recurrent abdominal pain seems to be accurate, safe and effective diagnostic and therapeutic procedure.

P089

Laparoscopic diagnosis and management of benign adnexal masses in postmenopausal women.

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AIM: The aims of the present retrospective study to determine the effectiveness of diagnostic laparoscopy for benigne adnexal masses and to discuss and evaluate the management of ovarian masses in postmenopausal women METHODS: We reviewed the records of 67 postmenopausal women, had treated laparoscopy between June 1990 and June 1995The presence of an adnexal mass was suspected on the basis of routine gynecologic examination in 22 cases, whereas by routine ultrasound scan in 45 patients. The mean patient age was 56.5 (range 50–63) years. All patients included in our study had a final histological diagnosis of benign tumor. RESULTS: The most frequent presenting sign was abdominal pain (21 cases) and two of these were associated with adnexaltorsion. In all cases were the procedures additionally operative. The histological findings were serous cyst 28, ovarianfibrome 8, muous cyst 7, paraovarian cyst 6, hydrosalpinx 2, endometrioma 16 Postoperative complications were rare CONCLUSION: It is suggested that in all postmenopausal women routine yearly pelvic examination and ultrasound scan is advisable. According to our results, we feel that surgical intervention with laparoscopy is justified in all cases of adnexal tumors in the postmenopausal women.

P090

The incidence of ovarianfibrome in a retrospective 10 years-study.

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Aim: The purpose of this study was to describe the frequency, clinical characteristics, and our experience in the surgical management of ovarian fibromas. Method: In an 10-years period during 1990–2000 ten women managed with the operative diagnosis of an ovarian fibroma and were reviewed retrospectively. All the patients included in our study had undergone laparoscopy and had a final histologic diagnosis of benign tumor. They had detected bei routine ultrasonographic examination. Results: These patients comprised 0,5% of all benign ovarian tumors seen over this study period. The ages of the patients ranged from 47 to 57 years and all were postmenopausal. About 40% of patients had no clinical symptoms. In the rest 60% the main presenting symptom was abdominal pain (63.5%). The diagnosis of an ovarian fibroma or a solid ovarian tumor was correctly made preoperatively in only 2 patients (20%). All tumors were unilateral, and the median size was 10 cm. Seven patients underwent conservative surgery. In three cases had undergone a total abdominal hysterectomy with bilateral salpingo-oophorectomy. No postoperative complications were noted. Conclusions: According to our results support conservative management of adnexal masses with benign ultrasound morphology incidentally detected at ultrasound examination in postmenopausal women. Gynecologists should be aware of this group of ovarian tumors despite their uncommon occurrence. The laparoscopic management of the benign adnexal masses seems to be a safe and effective therapeutic procedure.

PO91

The accuracy of diagnostic hysteroscopy in postmenopausal women with abnormal endometrial thickness

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Introduction: Hysteroscopy is an important complementary diagnostic tool used to determine the aetiology of ultrasound abnormal endometrial thickness.
Objective: To evaluate the accuracy of diagnostic hysteroscopy in postmenopausal women with abnormal endometrial thickness.
Material and methods: Retrospective study of all hysteroscopies that had been done at the department of Gynaecology of Santa Maria Hospital, between 1st April 2005 and 1st April 2006. All postmenopausal women with ultrasound abnormal endometrial thickness (>5 mm) were analysed. The following data were collected: age, symptoms and concomitant treatment. The correlation between hysteroscopic and pathologic diagnosis was also evaluated.
Results: We studied 100 postmenopausal women with ultrasound abnormal endometrial thickness that had been submitted to hysteroscopy. The mean age was 62.9 years old (48–83). The onset of menopause ranged between 38 and 56 years old. Fifty percent of women of our group were symptomatic (postmenopausal metrorragias). Seventeen percent of our population had been treated with hormonal therapy.
Endometrial polyp was the main pathologic entity found in our population (78%). We found a 90% correlation between the hysteroscopic and pathologic diagnosis.
Carcinoma diagnosis suspected by hysteroscopy in 2 symptomatic post-menopausal women were confirmed by pathology. All cases of atrophic endometrial seen in hysteroscopy corresponded also to the pathological diagnosis.
Conclusion: Hysteroscopy has a high diagnostic accuracy in postmenopausal women with abnormal endometrial thickness, and it has a significant correlation with the pathologic diagnosis.

P092

Endometrial disease in asymptomatic women-the role of hysteroscopy

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Introduction: The ultrasound diagnosis of endometrial disease is one of the most common indications for hysteroscopy.
Objective: To estimate the prevalence of benign endometrial disease in asymptomatic women and comparison of ultrasound, hysteroscopy and histological findings in this population group.
Methods: Retrospective study of the hysteroscopies in which material was collected for pathologic examination done at the department of Gynaecology during the last year (April 2005–April 2006). All asymptomatic women with ultrasound diagnosis of endometrial disease who were subsequently submitted to hysteroscopy were included.
Results: Sixty-seven cases were reviewed. The ages varied between 25 and 81 (mean-57,4 years). Seventy three percent were post-menopausal women. The relevant ultrasound findings were: polyp (40%), mioma (3%), endometrial thickening (44%), and localized endometrial thickening (6%). In what concerns polyps, the ultrasound had a lower sensibility (88%) than hysteroscopy (97%). In hyperplasia (endometrial thickening) both ultrasound (10%) and hysteroscopy yielded low sensibility, although hysteroscopy (80%) did far better. There were no cases of carcinoma detected.
Conclusion: Hysteroscopy is a good method to evaluate endometrial disease in asymptomatic women. Hysteroscopy is more sensible than ultrasound for the diagnosis of endometrial disease.