Gynecol Surg (2007) 4 (Suppl 1):S59–S79
DOI 10.1007/s10397-007-0311-8

ABSTRACTS

POSTER PRESENTATIONS

TOPIC 1 : ADNEXA

P-01

The value of surgical energies applying on ovaries in infertilied women with ovarian mass

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Background. Pregnancy incidence depends on ovarian tissue damage by electric or laser energy used at non-malignant ovarian growths (NMOG) surgery in infertiled women.
Object: to study the follicles changes after "high" surgical energies using in women with NMOG and sterility.
Methods. 78 patients with NMOG and sterility underwent laparoscopic surgery with electric and laser energies. Gonadotropic and steroid hormones were controlled. Ultrasonic and color doppler scanning (CDS) were performed.
Ho-Yag, Nd-Yag lasers and coagulation with bipolar and monopolar electrodes was performed.
Results. The changes in hormone levels in patients after surgical procedures were: increase of FSH with low or normal levels of LH in 22 (41,5%) patients; decrease of progesterone level and estradiol in II phase of menstrual cycle was detected at 14 (26,4%) patients. Hyperandrogenism was revealed in 6 (11,3%) of patients, increase of cortisol level in I and II phase of menstrual cycle-in 7 (13,2%), and hyperprolactinemia in I phase-in 4 (7,6%). US detected dominant follicles and yellow bodies in 23 (29,5%) patients in 3 months of follow-up and in 35 (44,8%) ps in 6 months.
CDS of ovarian vessels showed severe reduction of Vmax, Vmin and Vmean. Resistance, pulse indexes and systolic-diastolic ratio were also decreased. No significant improvement was noted in 6 months of following-up. Pregnancy after surgery was noted in 9 (11,5%) patients.
Conclusion. There is a correlation in of «high» surgical energies and ovarian dysfunctions in women with sterility who have undergone surgical procedures on account of NMOG.

P-02

Changes In Potential Of Fibrinolysis And Coagulation In Adnexa Laparoscopic Surgery

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Objective: Laparoscopic surgery appears to be less traumatic but its influence upon coagulation and fibrinolysis is incompletely elucidated. The aim of this study was to evaluate global functional tests of coagulation and fibrinolysis potential before, during, and after benign adnexa laparoscopic surgery.
Design & Methods: Blood samples were drawn on admission (sample 1), during surgery (sample 2) and on the first postoperative day (sample 3), in 50 patients undergoing elective benign adnexa laparoscopic surgery (uni or bilateral cystectomy / uni or bilateral adnexectomy). Samples were evaluated for clot lysis time (CLT) and endogenous thrombin potential (ETP) as global functional tests of fibrinolysis and coagulation potential.
Results: Mean age (±SD) was 35.5±10.58 years. Mean surgical time was 91.07±29.21 minutes (min.). No patient showed clinical manifestation of thromboembolic disease immediately after surgery or during a minimum follow-up period of 2 months. Levels of CLT were significantly different between sample 2 and 3, with lower CLT during surgery and higher than baseline after surgery (62.4±10.5 min. in sample 1; 56.5±10.8 min. in sample 2; 68.2±14.5 min. in sample 3). There were no differences between samples 1 and 2, 1 and 3 in CLT neither in ETP levels among the three samples. The pre and postoperative CLT were longer in older patients, multiparous patients, in patients with a higher body mass index and if a bilateral adnexectomy was performed. Smoker patients showed a shorter presurgical CLT. There were no differences depending on the mean surgical time.

Conclusions: These data suggest that laparoscopic adnexa surgery causes a decrease of fibrinolytic potential in older, obese and/or multiparous women as well as in those in whom a bilateral adnexectomy was performed. These patients could be considered at high thromboembolic risk and therefore routine thromboembolic prophylaxis could be recommended.

TOPIC 2 : CONGENITAL ABNORMALITIES

P-03

Endoscopic Modification Of David's Procedure: Correction of Mayer-Rokitansky Syndrome

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Mayer-Rokitansky syndrome belongs to the group of heterogenous disorders of female urogenital organs. The main component of this syndrome is vaginal aplasia or vaginal agenesis. Often it is associated with malformations of urinary tract and because of that surgical correction is extremly difficult. There are over 20 different types of procedures for correcting this anomaly. One of those procedures is creation of peritoneal vagina which can be created either by vaginal approach or combined vaginal and abdominal approach.

In the last four decades we treated 32 cases of Rokitansky syndroma by different techniques. 16 patient was treated by David's neovaginal surgical procedure using pelvic peritoneum as a epithelial coverage for tunnelisated neovaginal canal. Last four cases of operative correction was conducted by our endoscopic modification of David's neovagina formation meaining that intraabdominal part of David's operation (canalisation tracking and peritoneal suturing) is conducted by endoscopic methods. Tunelisation of neovagina is tracked with diaphanoskopy making this method of creating neovagina safe and secure. We had no complications during operative treatment of those patients. It is our opinion that our endoscopic modification is easier to be done than classical David's operation. As is usual with endoscopic procedures we had better results with postoperative pain and postoperative recovery. Patients in postoperative period are briefly monitored, from anatomic aspect (colposcopic analysis border between vaginal and periotenal epithelium) as well as psychic and sexual changes with our patients.

TOPIC 3 : ENDOMETRIOSIS

P-04

Is the rectovaginal location an intermediate stage of rectal endometriosis?

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Objective: To compare the history of pain complaints in women presenting rectovaginal and rectal endometriosis in order to show that rectovaginal locations may progress to a rectal involvement of the disease.
Design: Retrospective comparative study.
Setting: Department of Gynecology and Obstetrics, University Hospital Rouen, France.
Patients: Thirty two patients with rectovaginal endometriosis and 16 patients with rectal involvement.
Interventions: Standardized questionnaires recording the clinical history of painful deep endometriosis up to diagnosis.
Main Outcome Measures: Length of the time from the onset of pain until diagnosis, types of pain, disability related to the pain, number of physicians consulted before the diagnosis was made.
Results: Women with rectal endometriosis had an earlier onset of dysmenorrhoea (P=0.05). The age of dysmenorrhoea and the length of time between the onset of the first pain to the first time that the endometriosis was suspected were significantly increased in women with rectal endometriosis (P=0.01). Pain during defecation was more frequent in patients with rectal endometriosis (P=0.03). Women consulted an average of 3 physicians before the endometriosis diagnosis was suggested. The diagnosis of rectovaginal and rectal endometriosis was made by a non-gynecologist physician in respectively 26% and 31% of cases.
Conclusions: Rectal endometriosis is associated with an earlier onset and longer histories of painful symptoms until the diagnosis was made when compared to rectovaginal endometriosis locations. These observations support the hypothesis that rectovaginal location may be an intermediate stage of rectal endometriosis.

P-05

Endometriosis of the abdominal wall in postoperative abdominal scars

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Introduction: Endometriosis is reported in 15% to 44% of laparoscopies or laparotomies in women in the reproductive age group. Enometriosis of the surgical scar is often referred to the general surgeons because the clinical presentation suggests an incisional hernia.

Methods: We reviewed the medical records of six patients in the Department of Obstetrics and Gynecology of the Democritus University in Thrace for histologically proven abdominal wall endometriosis from January 2000 to December 2006.The main cause of presenting of patients was mass of the abdominal wall associated with increased pain during menstruation. Other presenting symptoms were: dyspareunia and dysmenorrhoea.

Results: All patients had a history of prior gynaecologic and surgical procedures: caesarean sections in three cases, in other two one laparotomy for surgical removal of uterine myomas, and in the last one case of a 38-year-old woman laparoscopic cholecystectomy.The age of patients ranged from 30 to 38 years (mean 33,5).The mean interval between the surgical procedure to the occurrence of symptoms was 3,5 years (range 1 year to six years).For praeoperativ evaluation was used ultrasound in four cases and in the other two one CT scan. All patients underwent surgery again ,and treated with wide local excision. Histopathological examination proved the diagnosis of abdominal wall endometriosis. None had evidence of pelvic endometriosis and none of them had recurrence. We observed nodule located on the cesarean section incision freely mobile in relation with the skin and the fascia in two cases, in case after cholecystectomy in laparoscopic trocar tract,in other two cases limited to the subcutaneous tissue and in the last one overgrows in the rectus abdominis muscle.

Conclusion: Abdominal wall endometriosis is a rare event and its diagnosis is difficult.

P-06

Endometriomas of the abdominal wall and pelvic endometriosis after caesarean section

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Introduction: Endometrioma is a well circumscribed mass of extrapelvic endometriosis and appears in 0.1 per cent of women who have undergone cesarean section. Extrapelvic endometriosis has been described in almost all body cavities and organs,including central nervous system,perineum and abdominal wall.Endometrioma has been documented in rectus abdominis muscle and primary cutaneous after surgical procedures..The aim of this study was to review ,our experience with abdominal endometriomas in combination with pelvic endometriosis especially after caesarean section.

Method: We present five cases of endometrioma appearing on the caesarean section scar. These women presented between January 2000 and December 2006 a triad consisting of periodic pain, associated with menses, history of cesarean section, and tumor inside a surgical scar approached the pelvic. The pain was cyclic and strongest just prior to menstruation

Results: The mean age of patients was 28.2 years (range 22–36).The mean interval between the gynaecologic operation to the presentation with endometrioma was 3.2 years (range 2 to 6) Ultrasound examination confirmed hypoechoic mass septated with cystic and solid components in the abdomen with intrapelvical communications The average size of the endometriomas was 5.9 (4 to 9 cm)>Surgical excision remains the treatment of choice. It was excised, with clear margins (to prevent recurrences), during the procedure. The patient was discharged after five days. The postoperative period and the follow-up at one and three months were uneventfulAll patients were treated with surgical excision, and the specimens had extra and intrapelvic endometriosis confirmed by histopathology

Conclusion: Extrapelvic endometriosis is a fairly rare phenomenon The cause of surgical scar endometriosis is believed to be iatrogenic transplantation of endometrium to the surgical wound We contend that endometrioma in scarring is a diagnostic pitfall that should be considered in the differential diagnosis of postoperative ventral hernias and various abdominal wall masses.

P-07

Bilateral cornual abscess after endometrial ablation following Essure sterilization

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OBJECTIVE
This is a retrospective study to evaluate the efficacy of complete laparoscopic excision of deep endometriosis with associated recto-sigmoidal resection in any case of necessity in those women that present pelvic pain or infertility in terms of achieving pregnancy and pain relief. The deep endometriosis is usually located on the utero-sacral ligaments and recto-vaginal septum.
METHODS
Since January 1996 to January 2006, 123 patients with symptomatic deep infiltrating endometriosis (DIE) underwent laparoscopic surgery to perform radical and complete excision of DIE. The age range was 21–54 years. The symptomathology was mixed between dysmenorrea, dyspareunia and infertility. 2 patients presented pyelonephritis with ureteral affectation and 42 patients had retrouterine nodules. 48 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 : 92) some of them with excision of rectovaginal nodules. Segmental ureter ablation (N :2), partial cystectomy (N:4), rectosigmoidal resection (N: 19), appendectomy (N: 6), and between them total hysterectomy was performed on 24 patients and total hysterectomy with bilateral anexectomy on 14 patients.
RESULTS
Of the 123 women, 8 of them presented minor postoperative complications (6.5%) like fever, abdominal distension, recto-sigmoidal stenosis and vesical atony. 6 patients (4.8%) had major complications including a rectovaginal fistula and an ureteral necrosis. 2 (1.6%) intraoperative laparotomies were done, one for haemorrhage and the other one for bowel injury. The recurrence after 12 months requiring iterative surgery occurred in 4 patients (3.2%). The follow-up was not too long, but the postoperative pregnancy rate was 54.8% (34 / 62). Amongst these 41.9% (26) had spontaneous pregnancy and 12.9% (8) through IVF. Pain relief was related by 105 patients (85.3%).
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. Nevertheless it is very important to inform the patients about the potential risks of this surgical procedure.

P-08

Gene expression study of differences between ectopic and eutopic endometrium

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Endometriosis, defined as the presence of uterine glands and stroma outside uterine cavity, is a complex disorder. Risk factors for developing the disease are distinctive genetic, environmental and immunological factors. The alternations in the expression levels of specific genes are involved in endometriosis, however the etiology and pathogenesis are not yet fully understood. The aim of our study was to define differentially expressed genes in ectopic compared to eutopic endometrium.
RNA was extracted from human ectopic (11 ovarian cysts) and eutopic (9 samples of normal endometrium) endometrium. All samples were obtained with a full and informed patient consent. Genes were selected based on the results of existing microarray data comparing human ectopic endometrium (ovarian endometriosis) with eutopic (normal) endometrium. The expression profiles were examined with TaqMan® Low Density Arrays, which are 384-well micro fluidic cards that enable the performance of 384 real-time PCR reactions simultaneously. The identification of the optimal set of normalization controls was made with GeNorm and the geometric mean of the best three genes (*YWHAZ*, *SDHA*, *RPL0*) was used as a normalization factor. The differences in the expression levels of the selected genes in the tissue samples were analyzed with the Mann-Whitney U test. Regulated genes were found applying the following filter steps: differences in p values of less than 0.05 and the fold change between endometriosis and control group medians more than 3. Of the182 genes studied, 76 genes were differentially expressed, 17 genes were found downregulated and 59 genes were found upregulated in ectopic tissue compared to eutopic. Moreover, based on the existing pathway information genes were arranged in different groups according to biological processes and pathways.
Our results indicate that many processes are disturbed in endometriotic tissue, including cell adhesion, immune

system, structural changes of extracellular matrix, angiogenesis, steroid hormone metabolism and other signalling pathways. The identifications of genes associated with endometriosis will provide a new insight into the pathogenesis of this disease.

P-09

Chronic Pelvic Pain In Patients With Endometriosis. Relationships Between Symptoms, Sites And Severity Of The Lesions

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Objective(s): Evaluate the prevalence of chronic pelvic pain, dyspareunia and dysmenorrhea in patients with endometriosis and the correlations between intensity and type of pain with the site and the extension of the endometriotic lesions.
Design & Methods: Prospective clinical study conducted between 2005 and 2007 in our Department of Obstetrics and Gynaecology. About 170 patients who underwent laparoscopic surgery for pelvic pain and/or endometriosis with definitive surgical diagnosis of endometriosis were included in the study. In all cases AFS, Adamyan and Enzian score were collected. Patients filled in a pain questionnaire about the intensity, type of pain (dysmenorrhea, no cyclic pain, dyspareunia, intestinal and urinary symptoms before surgical treatment. The correlations between endometriosis surgical scores with the type and intensity of pelvic pain were evaluated.
Results: in our study 93% of patients presented chronic pelvic pain, only 7% had no pain. The intensity of pelvic pain resulted more severe in the patients with deep infiltrating endometriosis in comparison to those with superficial and/or ovarian endometriosis. Dyspareunia was significantly more frequent and severe in patients with deep endometriosis (81 vs. 52%) and its intensity increases in relationship to the increase of deep endometriosis scores. Intestinal symptoms were evidenced in particular in the patients with deep infiltrating endometriosis.
Conclusions: The intensity and type of pain correlate with the severity of the endometriosis lesions and in particular with the presence of deep infiltrating endometriosis.

TOPIC 4 : GYNAECOLOGICAL ONCOLOGY

P-10

Hystological features of endometrium in women with breast cancer

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Introduction. Breast and uterus are estrogen and progesteron dependant organs where most malignant tumours of female reproductive organs occur. The aim of this study is to make a research by hysteroscopy and determine if endometrium in women suffering from breast cancer has any histological changes and research corellation between quantified expression of estrogen and progesteron receptors of breast cancer and endometrium.
Methods A retrospective and prospective, descriptive, targeted, controlled and open study covering the period from 2000 to 2005 involved 108 patients hospitalised in the Cantonal Hospital Zenica for malignant breast disease histologically verified and whose expression of steroid receptors was quantified by an immunohistochemical method. The hysteroscopical bioption of endometrium is performed.
Results. An invasive breast cancer occurs in 94.44% of all the examined patiens. The most frequent stages of breast cancer is IIa (35.19%), and according to histological type the most occurrent are ductale invasium (58.52%) and carcinoma lobulare invasium (12.96%). According to differentiation grade the most frequent is grade II (59.26%). A quantified expression of estrogen and progesteron receptor is identical (74% of positive and 26% of negative receptors) with a trend in expression distribution towards higher values.
Discussion. Hyperplastic changes on endometrium in 10% of cases in women suffering from breast cancer two years after the disease was detected which are asymptomatic and they are precursors of estrogen-dependent cancer. Ductal invasive breast cancer of the IIa clinical stage and the grade II of differentiation histologically correlates the most with atrophic endometrium found in 2/3 of examined patients and it is a precursor of estrogen-independent endometrium cancer. The distribution of the steroid receptors of endometrium in women with breast cancer is decreasing whereas the distribution of steroid receptors of breast cancer is increasing.
Conclusion. Women suffering from breast cancer fall within a risk group for uterus disease and must be examined by a gynaecologist more often.

P-11

Radical Vaginal Trachelectomy and Laparoscopically Pelvic Lymphadenectomy for Preservation of Fertility in Young Female with Early Cervical Cancer

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Introduction: radical trachelectomy (RTr) was developed by Dargent as an alternative surgical treatment for cervical cancer. The technique is performed by laparoscopic approach and vaginal route in the same way as a vaginal radical hysterectomy, but only the cervix is removed.
Method: 3 patients were included in our study with early stage cervical cancer and all desired fertility-sparing management. The procedure started with laparoscopic pelvic trans-peritoneal lymphadenectomy, the radical trachelectomy was carried out transvaginally, used Liga-Sure sealing vessels system and Ultracision harmonic scalpel for hemostasis for both approaches.
Results: the planned procedure was successfully completed in all patients. The median age was 31 years (range 28–32), all were nulliparous, 2 were with squamous cell carcinoma and one with adenocarcinoma. The patients were carefully followed up 1, 3, 6 and 12 months with clinical examination, PAP smears and routine ultrasound assessment. As complete clinical, cytological, ultrasound remission was confirmed to one year after the surgical procedure, we accepted that the patient try become pregnant, including gynecologist with great experience in the reproductive medicine.
Discussion: in early stage of cervical cancer, the most important prognostic factors are tumor size and presence of lympho-vascular spaces invasion. In the young women with cervical cancer with low risk factors for recurrence, preservation of fertility become an option. The more critical issues for morbidity from RTr are: is it effective in treating cancer and it is effective in maintaining fertility and maintaining pregnancy. RTr is an oncologically safe procedure in well selected patient with early stage disease.

P-12

Laparoscopic restaging of ovarian granulosa cell tumor: 3 cases report

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Introduction: Granulosa cell tumor (GCT) of the ovary is an uncommon neoplasm and is often diagnosed at an early stage. Surgery is necessary for definitive tissue diagnosis and staging. Complete staging as for epithelial ovarian cancer is recommended and a restaging procedure is frequently required. The staging procedure includes evaluation of paraaortic and pelvic lymph nodes, since retroperitoneal recurrences can occur especially in patients without retroperitoneum staging at initial diagnosis. The aim of this work is to describe the feasibility of the laparoscopic approach for the restaging of GCT.
Matherials and Methods: We present three cases of GCT of the ovary treated in our Institution over a period of 18 months (from August 2005 to January 2007). The patients were diagnosed an ovarian cyst and underwent laparoscopic adnexectomy. Hystology showed a GCT (one case of juvenile type of GCT in a 38 year's old woman). All the patients were submitted to laparoscopic restaging with pelvic and para-aortic lymphadenectomy.
Results: A median number of 32 lymphonodes was removed. Median duration of the operation was 195 min. No major intraoperative or postoperative complication occurred. Patients were discharged on the second or third post operative day. All the patients are well and without disease.
Conclusions: Laparoscopic restaging of GCT is feasible and allows para-ortic and pelvic lymphadenectomy.Patients restaged by laparoscopy benefit of a less invasive treatment.

TOPIC 5 : HYSTERECTOMY

P-13

Laparoscopic hysterectomy of enlarged uterus with primary uterine artery coagulation at its origin

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Objective: To argue the usefulness of carrying out total laparoscopic hysterectomy with primary uterine coagulation at its origin through a series of women with an enlarged benign uterus.
Methods: This was a retrospective study including consecutive women having undergone this technique in a university hospital during 14 months. Inclusion criteria were enlarged benign uterus weighting more than 280 g. Data concerning patients, surgical procedure and outcome were provided by the medical chart. Relationship between uterine weight and length of the surgical procedure was estimated by the correlation coefficient r.
Results: Sixteen women meeting inclusion criteria benefited from this technique. Median values (range) for age, body mass index, and parity were respectively 47 years (41–53), 25.3 kg/m2 (19.3–34.9) and 2 (0–3). The median value of

uterine weight (range) was 521 g (280–1015). The median length (range) of surgical procedure was 185 min (120–260). The longest procedures were due to associated deep endometriosis resection (two cases), to extensive adhesiolysis (one case) and to long uterine morcellation stage (two cases). The correlation coefficient r was -0.06 (P=.83) showing that the length of the intervention was not significantly related to the uterine size. We registered no preoperative and postoperative complications.
Conclusion: The selective coagulation of the uterine artery at the origin is a reproducible technique that allows either laparoscopic or laparoscopic-assisted vaginal hysterectomy in enlarged uteri. Moreover, it avoids unexpected peroperative hemorrhage requiring conversion to the abdominal route with optimal safety for the ureter.

P-14

Cervical stump extirpation via laparoscopic access
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Subtotal hysterectomies are widely discussed in medical literature of recent years as time saving simple procedures. The relevance of such operations remains unclear. Recently some authors demonstrated low quality of life after subtotal hysterectomy. The objective was to standardize the technique of laparoscopic cervical stump extirpation.
Design and methods. 48 patients were enrolled in the study. They suffered subtotal hysterectomy from 1 to 8 yrs earlier. Main indications for the 1st operation were: uterine myoma, adenomyosis, and ovarian masses. Preoperative evaluation revealed problems connected with the retained stump: decreased libido, relapses of bleeding episodes, pain, CIN 2–3. We propose the following steps for this operation: dissection of round ligament, opening of parametrium and identification of ureter, dissection of infundibulopelvic ligament. Only after that one could mobilize the bladder after proper dissection of sacrouterine ligaments. The next crucial step is to identify and mobilize pubovesical fascia and to convert all the procedure into safe intrafascial technique. Only after this step the coagulation of uterine vessels is possible in safe manner. Cervical stump was removed using unipolar current. Vaginal cuff was stitched with vycril 2–0. Knots were formed extracorporally. Mean operating time was 72, 6 min (54–196 min). Two complications were registered: bladder and small bowel injury. We treated them laparoscopically. All patients considered the quality of life between good and excellent in 2–5 year follow-up.
Conclusions. Indications for subtotal hysterectomies should be meticulously revised. Cervical stump extirpation remains one of the most difficult challenges.

P-15

Minimally Invasive Surgery for Benign Uterine Pathology: New Trend in Private Hospital for Obstetrics&Gynecology, Skopje, Macedonia
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Introduction: this study was to profile laparoscopic (LAVH), vaginal (VH) and abdominal (AH) hysterectomies done in private hospital. With minimally invasive surgery (MIS) to treat uterine problems available, we were interested in characterizing changes in the performance of hysterectomy.
Methods: 406 female underwent a hysterectomy, between Jan. 2003 and Dec. 2006, except patients treated for a genital cancer. All the operations took place a technique described with main characteristics for benign condition, duration, equipment, hemostasis was achieved with Liga-Sure sealing vessels system or Ultracision harmonic scalpel. For each operation, specifically for MIS, data was entered: ultrasound to calculate uterine fibroids, caesarean section or adhesion causing abdomino-pelvic surgery, associated surgical procedure during technique (colposuspension, IVS, TOT, meshes), conversion to laparotomy, intra-operative complications and injuries, uterine weight, blood transfusion, hospital stay.
Results: in 2003, 31 (49%) of the hysterectomies were done with laparotomy, 7 (11%) by vaginal way and 25 (40%) with LAVH, wherewith, MIS (LAVH and VH) was 51%, a conversion to laparotomy were necessary in 2 (3%) cases. In 2006, 35 (30%) were AH, 28 (24%) were VH, 54 (46%) with LAVH, with MIS were 82 (70%) of patients, without conversion to laparotomy. 2 bladder injuries by LAVH procedure were done, one managed by laparotomy, second with laparoscopy, successfully.
Discussion: from 2003 to 2006 trend shift of the operative technique has been seen in private hospital in Skopje, Macedonia, increasing the LAVH, with high initial level of the MIS 51% at the beginning of active surgery in the hospital.

TOPIC 6 : HYSTEROSCOPY

P-16

Hysteroscopic outcomes in our clinic: 5 Years experience
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Objective: The documentation of outcomes of hysteroscopic procedures carried out at Selcuk University, Meram Medicine Faculty, Obstetrics and Gynecology Department in 2002–2006 years.
Materials and Methods: 248 patients that have undergone hysteroscopy were included into the study. Operative indications and results were detected retrospectively.
Results: There were 94 primary infertile patients, in 17 of these polypectomy, in 8 patients diagnostic hysteroscopy together with laparoscopy, in 47 patients uterine septum resection and in 22 patients hysteroscopic synechiolysis for Asherman's syndrome were carried out. There were 118 secondary infertile patients that had hysteroscopy for diagnostic purposes together with laparoscopy in 15 patients, for septum resection in 40 patients that had uterine anomaly, for habitual miscarriages in 25 patients, for polypectomy in 18 patients, for synechiolysis in 20 Asherman's syndrome patients. There were 7 patients with dysfunctional uterine bleeding and hysteroscopic endometrial ablation was performed for these patients. In 9 patients hysteroscopy was done to take out ectopic intrauterine device. In 8 patients hysteroscopic polyp extirpation and in 12 patients hysteroscopic sub-mucosal myomectomy was performed. Among 248 hysteroscopic procedure, 8 cases complicated with uterine rupture, there were no other major complications related to procedure, so our complication rate was 3.2%.
Conclusion: There is a wide spectrum of hysteroscopic procedures and we wanted to demonstrate our own results.
Key Words: Hysteroscopy, hysteroscopic outcomes.

P-17

Hysteroscopic metroplasty: Versapoint® versus classical technique

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Objective: to determine the feasibility and safety of hysteroscopic metroplasty with Versapoint compared to classic technique for the treatment of septate uterus and to assess pregnancy rate as well as the reproductive outcome after these procedures.
Design & Methods: sixty three women with partial septate uterus diagnosed in our endoscopy centre of Department of Gynecological Science and Human Reproduction of Padua from January 2001 to June 2005 were enrolled in the study. Forty-two underwent hysteroscopic metroplasty using the Versapoint device (23 nulligravida) and 21 resecto-hysteroscope with Collins loop (10 nulligravida), all under general anesthesia (Diprivan, Fentanest). In all women a second-look office hysteroscopy was performed within 2 months after the surgery. Operating time, complications as well as pregnancy rate and mode of delivery were recordered.
Results: operating time was significantly lower in the group treated with Versapoint device: 20.5±9.6 minutes versus 15.4±6.2 minutes ($p<0.05$). Cervical lacerations complicated metroplasty in 2 (9,5%) nulliparous women treated with Collins loop. Office hysteroscopy, performed after two months, confirmed complete removal of the septum in 20 (95.2%) patients of group 1 and in 39 (92.9%) patients of group 2. Pregnancy rate, delivery rate and miscarriages were similar in both groups.
Conclusions: the operative hysteroscopy with Versapoint device is a procedure easier and safer than classical technique. It does not require a cervical dilatation that traumatizes the cervix and increases the chances of a later cervical incompetence and it avoids cervical lacerations and uterine perforation. Moreover the bipolar electrodes allow to achieve a better hemostasis because of the vaporization effect on the tissue, thus the procedure can be accomplished more quickly avoiding cutting into myometrium. As an alternative to classical technique, we support that the hysteroscopic metroplasty with Versapoint (operative hysteroscopy 5,2 mm and bipolar loop) has the same effectiveness and could be used predominantly in nulligravida women with severe cervical canal stenosis.

P-18

A new method to increase success rate and patient acceptance of Essure® hysteroscopic tubal sterilisation

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Since the initial publication by John Kerin in 2001, hysteroscopic tubal sterilisation by the ESSURE procedure has expanded rapidly throughout the world because of its minimal invasiveness and very low morbidity rate compared with laparoscopic sterilisation. One of the major factors explaining this improvement in morbidity is that general anesthesia is not needed.
On the other hand, transvaginal procedures without anesthesia can cause pain associated with passage through the cervical canal or with movement of the endoscope in the uterine cavity. The diameter of the most commonly used Bettocchi surgical hysteroscope contributes to the pain and may lead to placement failure when the instrument does not fit the diameter of the cervical canal. Use of local anesthesia can prevent the pain perceived during passage through the cervix, but it does not resolve the problem of cervical stenosis. Moreover use of paracervical block requires placement of a speculum and an injection into the vaginal wall which may also be painful.

We resolved these two problems in our daily practice by removing the external surgical sheath of the hysteroscope and therefore reducing the diameter of the hysteroscope from 5.0 mm to 4.3 mm.
A retrospective study comparing 100 patients showed a significant diminution in intraoperative (assessed by a visual analog scale) and postoperative (assessed by use of analgesics during the first 2 hours) pain and increasingly rare use of local anesthesia (and very exceptionally, general anesthesia), for very narrow cervices. We observed no significant difference in the duration of the procedure or its success rate, either immediate or at 3 months.
This technique thus makes it possible to improve the patients' experience of the procedure. In the absence of continuous flow, it requires working both at low pressure and rapidly, to avoid endometrial edema. Bleeding must also be avoided. Accordingly this technique requires an experienced operator.

P-19

Hysteroscopic Sterilization with Essure® in Outpatient Management

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Objective: The author reports her experience using the Essure device in an ambulatory sterilization procedure, presenting data about safety, tolerance and effectiveness.
Methods: The Essure method of sterilization offered to the couples that whish permanent birth control, without contraindications. After the informed consent, the procedure scheduled during the early proliferative phase or at any time, but menstruation, if the woman was under hormonal contraceptives. The Essure micro-insert is placed under hysteroscopic visualization in the proximal portion of the Fallopian tubes. The patients leave the ambulatory unity after two hours and scheduled for evaluation at tree month, by ultrasound. The author analysed retrospectively all clinical files and evaluated safety and tolerance of the procedure and effectiveness of device placement.
Results: From April 2003 to April 2007, 121 women underwent Essure placement procedure. Bilateral device placement achieved in 115 (95,04%) patients. In 3 (2,48%) cases a second procedure was necessary for bilateral placement, 2 of them without success on two sites placement. In 2 cases the woman only needs one placement, (previous Salpingectomy), what was accomplished. The placement failure in 4 cases (3,30%.) The Essure procedure was done in 2 (1,66%) patients without medication, 10 (8,26%) patients had diclofenac 75 mg, 30 minutes before, 12 (9,91%) had paracervical block, 97 (80,16%) had paracervical block and sedation. The procedure was very well tolerated, in most of the cases. The major complication occurred in a case of tube spasm during the left device placement with complaints from pain at discharge. With suspicion of perforation, the woman, submitted at surgery presented tube perforation and treated by salpingectomy. The most frequent minor complaints are spotting the following week and pelvic or back pain, without need of medication the day after in 113 (93,3%) women. At present 116 (95,86%) women have successful Essure placements, without pregnancies.
Conclusions: The Essure placement had low rate of complications and the major difficulties are associated to the learning period of the operator. The hysteroscopic sterilization by Essure micro-insert, is a safety, well tolerated and accepted method for permanent contraception on ambulatory sterilization procedure.

P-20

Concomitant intrauterine procedures and placement of Essure® micro-inserts for tubal sterilisation

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Placement of Essure® micro-inserts for tubal sterilisation began in France in 2001. In our department, most sterilisations are now performed hysteroscopically. Other disorders of the uterine cavity are sometimes discovered during the consultation for sterilization. Until now, no study has formally demonstrated the possibility of performing an intrauterine surgical procedure concomitantly with ESSURE micro-insert placement.
We therefore conducted a retrospective case-control study in our Obstetrics and Gynecology department in the greater Paris metropolitan area.
The study included all patients who underwent tubal sterilisation with Essure® inserts, with or without another intrauterine procedure from January 2004 through December 2006. We assessed and compared the success rates for micro-insert placement and complications during the first three months.
In all,155 patients had Essure® micro-inserts placed, 32 of them with another intrauterine procedure. The procedures combined with Essure® micro-insert placement were: endometrectomy (n=18), myoma resection (n=5), polyp ablation (n=6), curettage (n=2), IUD removal (n=3), removal of an insert that migrated into the uterine cavity (n=2). Three patients had 2 or 3 of the procedures together with the Essure® placement. The success rate for bilateral and unilateral Essure® placement was 97.6% (n=120) without any other procedure and 96.9% with another procedure. The complication rate in the group with Essure® placement only was 4% (n=5) compared with 9.4% in the

other group. No cases of expulsion, perforation or pregnancy were reported.
The practice of another intrauterine procedure during hysteroscopy for sterilization is possible without reducing the placement success rate and without increasing the morbidity for the other procedure. These results should be confirmed by subsequent prospective studies in larger cohorts.

P-21

Is hysteroscopy safe in everyday practice?

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Objective. The aim of this study is to evaluate safety of operative hysteroscopy and to analyze the cause of complications.
Design and methods. All hysteroscopies performed during 2005–2006 year period in the Gynecological department were analyzed. All complications were estimated according to the patient age, time when the complication occured, founded pathology and the experience of the surgeon.
Results. 833 hysteroscopies were performed during years 2005–2006 in the Gynecological department. The only complication which took place during hysteroscopy was perforation of the uterus. There were 9 (1,1% of all hysteroscopies) perforations, 3 in a year 2005 and 6-in a year 2006. 8 perforations were made during the cervix dilatation and 1-directly with hysteroscope. The mean age of these patients-54,3 years (42–75 years), most of them were perimenopausal. In all cases we found benign endometrial pathology-hyperplasia or polypus. Residents performed 21% of all hysteroscopies, and rate of their complications was 56 % (5 of 9).
No other complications occured during hysteroscopies.
Conclusions. Operating hysteroscopy is a safe procedure with very low rate of complications. The most expected complication-perforation of the uterus-occurred during dilatation of the cervix. Rate of complications is directly related with surgeon's experience.

P-22

The efficacy of transvaginal ultrasound examination providing pathology in the cavity of the uterus

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Objective. Aim of the study was to estimate the efficacy of transvaginal ultrasound examination (TVE) in predicting endocavital pathology of the uterus.
Design and methods. All hysteroscopies performed in the Gynecological department during the year 2006 were analyzed. Routine TVE was performed and pathological findings in the cavity of the uterus were the reason for performing operating hysteroscopy. The time between TVE and hysteroscopy was less than 14 days. Intraoperative findings and histological results from operative material were compared with the initial data.
Results. 529 hysteroscopies were performed in the Gynecological department in 2006. 507 (96%) of all procedures were done when pathology in the cavity of the uterus was suspected by TVE, and 22 (4%)-for diagnostic reasons without pathological findings. Endometrial polypus were suspected in 342 cases (65%), submucosal myoma in 80 cases (15%), hyperplasia in 81 case (15%) and septum of uterus in 4 cases (1%). After hysteroscopy diagnosis of polypus was confirmed in 321 cases, submucosal myoma in 79 cases, hyperplasia in 94 cases, endometrial cancer in 8 cases, septum of the uterus in 6 cases. No pathology was found in 21 cases-in 18 cases when pathology wasn't suspected by TVE and only in 3 cases when endometrial polyp was suspected. General accuracy of the TVE for predicting endocavital pathology was 99%.
Conclusions. TVE is a very effective method for predicting pathology in the cavity of the uterus. If TVE is performed properly, there is no need to perform office hysteroscopy before operating hysteroscopy.

P-23

Concerns On Unilateral Placement of Essure® Device

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Introduction: Patients' selection and follow-up criteria after Essure procedure are clearly established. However, whenever unilateral placement is indicated, some changes are advised in the protocol.
Methods: Seven over 222 patients for a five-year period were submitted for unilateral placement of the Essure device. There were three cases of previous tubal ectopic pregnancy, one case of adnexectomy because of a borderline ovarian tumor, one case of previous surgery of a non-developed uterine horn and one cases of severe adhesions in one uterine cornua. Inclusion criteria asked for histology of the lacking tube and/ or adnexa to assure the condition.
Results: Insertion took place without complications and lasted a mean of two minutes less than the conventional bilateral procedure. In one patient, dense adhesions in the right uterine

cornus prevented from finding the tubal ostium and only one device was inserted. Posterior HSG showed preoperative lack of tubal patency. Follow-up included both pelvic X-Ray as requested in the approval document and vaginal ultrasound. All of them were correctly placed by the latter.
Discussion: All recommendations for inclusion and exclusion criteria and explorations for the follow-up of the Essure procedure were made in the belief that placements would be bilateral. Nevertheless, some patients need only one device, either because of congenital malformations or surgery. Some precautions should be taken into account. The need of histology to assure previous salpingectomy or adnexectomy, or, in case of doubt, a HSG prior to insertion are obliged to discard the bilateral insertion. Follow-up with pelvic X-Ray informs just about pelvic placement of the device, while the comparison with the contralateral microinsert is not feasible. Thus, ultrasonographic follow-up becomes mandatory.
Conclusion: Some precautions should be carried out when unilateral placement of Essure is indicated. We suggest that these recommendations are included in the leaflet in the near future.

P-24

Initial Experience, Of A Public Hospital, Using The Essure® Hysteroscopic Tubal Sterilization Device, In An Outpatient Setting

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Introduction: The aim of this study is to present our initial experience and evaluate the results of Essure procedure, in 61 patients, in an outpatient setting.
Methods: Retrospective study. Ambulatory surgery unit, of a Gynaecology service, of a public hospital. Women who, between December 2004 and February 2007, asked, and met the manufacturer criteria, for tubal sterilization by hysteroscopy, Two surgeons only performed all the procedures. Essure micro-inserts were placed under hysteroscopic visualization, using intravenous sedation, paracervical block or no anaesthesia at all. Demographic data, mean operative time, intensity of pain, success rate of device implantation and confirmation of correct placement were collected and analysed. Patient satisfaction was accessed through a telephonical query.
Results: Sixty one women were included. All caucasians, mean age 36,7 years (range 25–46 years), mean parity 2,45 (range 1–5 para) and average body mass index of 28,9 (range 16,7–45,7). Sedation was used in 8 patients (13,1%), paracervical block in 49 (80,3.%) and no anaesthesia in 4 (6,6%). Mean operation time was 16,6 minutes (range 10–40 minutes). Successful placement was achieved in 54 patients (88,5%). No major intra or postoperative complications were detected. At the third month, all 54 had either a pelvic x ray (33 patients, 61,1%) or transvaginal ultrasound (21 patients, 38,9%). In 11 cases (20,4%), with inconclusive results, a HSG was performed with 100% bilateral tubar occlusion confirmation. In the 3 to 29 month follow up of our series, all women, except one, found the procedure highly acceptable (98,1%). No pregnancies have been reported to date. One patient was lost to follow up.
Discussion: In our institution and experience, Essure seems to be a safe, effective, minimally invasive procedure, in an outpatient setting, with high patient acceptance, performable with paracervical block in most of the cases, or with even no anaesthesia in some others. In accordance with the literature, in our series, Essure system seems to be a realistic alternative to laparoscopic sterilization.

P-25

Uterine Hemangioma: An Unusual Hysteroscopic Finding

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Introduction: Uterine hemangioma is a rare benign vascular neoplasia, many times underdiagnosed due to an atypic clinical appearance. Histologically it results from the proliferation of both arteries and veins with thick-walled vessels that can extend through the full thickness of the myometrium. Uterine hemangiomas can be subclassified as capillary, cavernous or venous, depending on the appearance of the vessels. There are no clinical differences between the subtypes. Capillary hemangiomas of the cervix are the most common vascular tumors of the uterus. Hemangiomas of the corpus are uncommon, and they vary considerably in size. In most cases their diagnosis is made histologically. In some cases of large hemangiomas, hysterectomy is necessary to control bleeding. There are cases that have been managed successfully by intra-arterial embolization. Case Report: Identification: S.M.O.M.S., a 29-year-old, caucasian, nulliparous woman, menarche at 9 years, without relevant personal or family medical history. Present history: progressively aggravating menometrorrhagia since menarche. Transvaginal ultrasound:"...anteverted uterus, measuring 62×25×37 mm, with focal endometrial thickening..." Saline-infusion hysterosonography:"...focal intracavitary, bilobulated mass, measuring 25×15×28 mm..." Surgical procedure: submitted to diagnostic hysteroscopy, revealing a pedunculated mass, measuring 25 mm; bipolar resectoscopy was performed. Histopatho-

logic evaluation:"...benign vascular neoplasia-hemangioma"
Discussion: The saline-infusion hysterosonography is an important mean of evaluation associated to transvaginal ultrasound in cases of focal intracavitary lesions. The clinical status of the patient after lesion removal was favourable, as described in literature. In cases of large intracavitary lesions, a previous diagnostic biopsy can be useful in order to prevent hemorrhagic situations, which would require emergent hysterectomy to control bleeding, or to program their therapeutic orientation by intra-arterial embolization.

P-26

Endometrial calcifications: case report

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Introduction: Endometrial calcifications are related in most cases with repeated curettages and endometritis in young women and may cause recurrent abortions and infertility. The authors describe a case report of endometrial calcifications related with irregular uterine bleeding after a caesarean section.
Case Report: A case report of a 27 years old woman, gravida-1, para-1, and a finding of endometrial calcifications 5 months after a caesarean section. An ultrasound was made 4 months after the caesarean section because of irregular uterine bleeding, which revealed an hyperecogenic endometrial area. She underwent a diagnostic hysteroscopy with biopsy. Histology established the diagnosis of calcium deposits.
Discussion: The aetiology of endometrial calcifications is multiple, including recurrent abortions (bony tissue may be caused by retained fetal tissue undergoing dystrophic calcification), endometritis, osseous metaplasia or calcium deposits in vascular tissue. Caesarean section or even pregnancy may be a risk factor for these findings. The aetiology and symptoms determine the actuation. If an osseous metaplasia is found, it should be removed. If the patient is asymptomatic with dispersed calcium deposits, the conduct should be restricted to diagnostic confirmation with hysteroscopic biopsy.

TOPIC 7 : IMAGING

P-27

The role of intraoperative ultrasonography in gynecologic surgery as an efficient fibroid detection method

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Objective: To assess the myoma detection efficacy of intraoperative ultrasound performed directly on the uterus.
Design and Methods: We performed a prospective study on 63 women undergoing surgery for uterine fibroids. Patients were divided into two groups: 22 women submitted to hysterectomy and 41 women submitted to laparotomic myomectomy. Subsequently, in order to detect the number of myomata, we studied the patients by means of intraoperative ultrasound (IUS) and intraoperative uterine palpation (IP). In the hysterectomy group this was done on the intact uterus at the beginning of the intervention while in the myomectomy group it was performed at the end of the surgery with the aim to detect residual fibroids. In addition, in the hysterectomy group the number of fibroids was recorded by the anatomo-pathology (AP).
Results: the average number of fibroids detected at the end of surgery in the two groups (5.33±3.27 vs 4.73±5.93) was homogenous. In the hysterectomy group the comparison between the number of fibroids at IUS and at AP did not reveal any significant difference. The same was observed between IP vs AP and IUS vs IP. On the contrary, in the myomectomy group the comparison between the number of residual fibroids identified by IUS (0,76 +/− 1,52 SD) and the number of residual fibroids palpated by the surgeon (0,10 +/− 0,30 SD) showed a significant difference ($p=0.0014$).
Conclusions: we believe that IUS performed on the intact uterus to identify myomata has a high detection rate and is as effective as the IP. Conversely, the results obtained from the myomectomy group demonstrated that IUS was more efficient than palpation in detecting residual myomas at the end of the surgical operation. In view of the fact that recurrence of uterine leiomyomatosis is often caused by residual disease, intraoperative ultrasound could be employed to detect all fibroids in conservative procedures, thus reducing the recurrence rate.

P-28

Uterine fibroids and the diagnostic power of ultrasonography

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Objectives: To correlate preoperative ultrasound examination with intraoperative and anatomo-pathological findings regarding the estimation of number, location and size of uterine fibroids, uterine diameters and volume.
Design and Methods: We performed a prospective study on 63 patients undergoing surgery for uterine leiomyomatosis. The patients were divided into two groups: one submitted to laparotomic myomectomy and another submitted to hysterectomy. Ultrasound scans (US) were performed within 1 day of admission to the operating theatre.
The number, location and size of myomata at ultrasound were compared to intraoperative visualisation and anatomo-pathological (AP) findings. Uterine diameters and volume were also recorded and compared to AP findings.
Results: we did not observe any significant difference between the number of leiomyomata recorded at visualisation and at US, while there was a significant difference between visualisation and AP (P=0.0006). If the number of myomata was less than or equal to six, the analysis showed a non-significant difference between myoma number detected at US and that observed at AP in the two groups. Contrarily, we found a significant difference if the number of myomata was more than six (P=0.003). With respect to the size of myomata, there was no significant difference between US and AP in the hysterectomy group, while there was a significant difference in the laparotomic group (P=0.001).
Conclusions: with regard to the determination of myoma number, visualisation is comparable to US but not to AP findings in both groups. Our data reveals not only that US is a good method to identify the size of myomata in patients submitted to hysterectomy but also a good approach to evaluate the number of fibroids if less than or equal to six. We also observed a decrease of US diagnostic efficiency, with respect to AP, with the increase of uterine volume. As a consequence, patients with more than six myomas, voluminous uterus and need for an accurate uterus mapping, would be better studied with a more expensive and demanding second-level examination like MRI.

P-29

Adequate investigation of meno-and metrorrhagia

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Background
Women with menorrhagia and/or metrorrhagia often suffer from substantial reduction in quality of life due to a delayed assessment, diagnosis and treatment. Inadequate assessment will often lead to unsatisfactory treatment results.
Material and methods
We present the results from 104 women with menorrhagia or metrorrhagia referred to a specialized bleeding policlinic. Bleeding abnormalities were characterized as menorrhagia and metrorrhagia. Mean age was 43.3 years (range 28–54 years). All women underwent bimanual palpation, transvaginal ultrasound (TVS) and saline instillation sonography
Results.
Polyps and fibroids were found in 58 women (56 %) of 104 women. In women with menorrhagia , polyps and fibroids in the uterine cavity were found in 64%: The corresponding figures, for women with metrorrhagia were 48.1%.
Twenty-four of the women had been treated with levonorgestrel intrauterine system (LNG-IUS) without success. In these women intrauterine pathology were found in 54%.
Conclusion
These results indicates that in women with menorrhagia or metrorrhagia extended examination should be offered. This includes visualisation of the uterine cavity, either with saline instillation sonography or hysteroscopy.

TOPIC 8 : NEW DEVELOPMENTS (instruments, techniques and procedures)

P-30

Holoprosencephaly: A rare case of abnormal findings during transcervical embryoscoping 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. The embryo is examined during the first trimester of gestation through the intact membranes, by introducing a rigid endoscope into the coelomic space via the cervix.

Later, the chorion fuses with the amnion and makes the procedure impossible.
Holoprosencephaly is the commonest brain malformation in humans. It includes a range of abnormalities, due to failure in septation or clearage, of the midline forebrain structures (hemispheres and basal ganglia). The total prevalence (cases/10000 live births, still births and terminations of pregnancy) ranges from 0.72–1.20, whereas the birth prevalence (cases/10000 live births and stillbirths) ranges from 0.49–0.88.
It is frequently accompanied by effects on the development of the midfacial region. Its clinical associations include diabetes (which appears in 70% of classical cases), hypothyroidism (11%), hypocorticism (7%), GH deficiency (5%). Its etiology includes chromosomal anomalies (Trisomies 13,18), syndromes (Smith/Lemli/Opitz, Hall/Pallister, Pseudotrisomy 13, Meckel), Familial/Single-gene cause (mutated Sonic Hedgehog, SIX3, SHH, GLI2, TGIF, TDGE1, ZIC2, FAST1, PTCH), environmental factors (Alcohol, Retinoids, methotrexate).
We present the embryoscopic features of a holoprosencephalic fetus, attributed to trisomy 18, during the 12 week of gestation of a primigravida, aged 32 yrs.

P-31

Siamese Twins: A rare case of abnormal findings during transcervical embryoscoping 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. The embryo is examined during the first trimester of gestation through the intact membranes, by introducing a rigid endoscope into the coelomic space via the cervix. Later, the chorion fuses with the amnion and makes the procedure impossible.
Siamese twins result from an unseparated multiple pregnancy, mainly with two fetuses who are monozygotic, predominantly monoamniotic, and supported by the same yolk sac. The prevalence is 1 in 250000 live births or 1 in 50000–100000 of all births, whereas there is a strong female predominance (3:1). In order to determine the unclear etiology, the following opposing theories have been developed: The Fission Theory, which is based on the delayed division of the ovum, between the 13th-15th day postconception and the Fissure Theory, which supports that embryos fuse hours/days after the fertilization, in which they are independent from one another.
We present the embryoscopic features of a case of thoracopagus and craniopagus siamese twin pregnancy, attributed to maternal uniparental disomy, during the 9th week of gestation of a primigravida, aged 32 yrs.

P-32

Optimising the feasibility of outpatient hysteroscopic sterilisation (Essure®) in an outpatient 'office' setting

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Introduction: To determine the feasibility and identify factors predictive of technical success, of female sterilisation using the Essure™ system in an outpatient hysteroscopy clinic without conscious sedation or general anaesthesia.
Methods: Demographic and procedural data were prospectively collected from 169 consecutive women undergoing outpatient hysteroscopic sterilisation without sedation or general anaesthesia. A hysterosalpinogram (HSG) was performed routinely in all patients 3 months following the procedure to confirm bilateral tubal occlusion. Multivariable logistic regression was used to identify factors independently predictive of successful completion of the procedure. The main outcome measures were technical feasibility, predictive factors for technical success (operator, BMI, uterine size, axis, menstrual phase and cervical stenosis) and complications.
Results: Successful bilateral tubal placement of the Essure™ microinserts was achieved in 155/169 (92%, 95% CI 87% to 95%)women. Non-secretory phase of the menstrual cycle (P=0.04) and a clinically normal sized uterus (P=0.003) were independently predictive for successful completion of the outpatient procedure on multivariable modelling. There were no major procedure-related complications recorded, but transient vaso-vagal reactions occurred in 10/169 (6%). Bilateral tubal occlusion was confirmed on hysterosalpingogram in 165/169 (98% (95% CI 94% to 99%)) cases at 3 months and 100% at 6 months.
Conclusion: Outpatient hysteroscopic sterilisation using the Essure™ system without sedation or general anaesthesia is a successful and safe procedure. If practical, women should be scheduled to have their procedures in the proliferative phase of the menstrual cycle to optimize successful placement of Essure™ devices, especially if the uterus is clinically enlarged.

TOPIC 9 : OFFICE ENDOSCOPY

P-33

New laser techniques in infertiled women: diagnosis and treatment within office cervico-and hysteroscopy

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Objectives: To evaluate the effectiveness of laser energy wavelength 248 nm in case of severe inflammation in cervix and uterus associated with infertility.
Design and methods: 35 women age of 27 to 36 (32±0,3) with infertility had undergone office hysteroscopy. Bacteriological, histological, immunological and immunohystochemical investigations had been done.
Laser energy was delivered to vagina, endocervix and uterus by means of flexible lightguide. When no inflammarory features were determined, high power laser energy within office hysteroscopy was used to remove adhesions. Small doses of UF laser were used to improve E_2 and P receptor's activity. No antibiotics were used.
Results: UF laser showed high antibacterial and immunomodulated effect.
In most patients (96%) the reduction of amount of aerobes and anaerobes from 10^8 to 10^3 and total elimination was obtained.

P-34

Transvaginal endoscopy (TVE)-what is the real significance of "subclinical" lesions?

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Objectives: transvaginal endoscopy (TVE) can verify periadnexal microadhesions and foci of endometriosis hardly detectable with standard laparoscopy. The aim of the study was to document the occurrence of "subclinical" lesions detected in infertile women and their clinical significance.
Design and methods: 94 infertile patients were enrolled in whom TVE was performed at least 12 months before evaluation. Couples with male subfertility were excluded. If no major pathology detected, timed intercourse in following 3–6 months was adviced after ovulation monitoring. If no pregnancy occurred, 2–3 intrauterine inseminations were performed after mild stimulation with gonadotrophins followed by in vitro fertilisation (IVF) if infertility persisted. The results of this therapeutic approach were recorded according to the result of initial TVE finding.
Results: In 38 women no pathology was detected (40,4%), abnormal finding was documented in 56 (59,6%) infertile women. The most frequent pathology found was endometriosis in 36 women (38,3%) followed by tubal infertility in 18 patients (19,1%). In study group pregnancy was confirmed in 66 women (70,2%), 28 couples (29,8%) are still remaining childless. Pregnancy was documented in 24 women with normal TVE finding (63,2%), 22 women with endometriosis (61,1%) and in all cases (18 patients) with tuboperitoneal infertility. There was no spontaneous conception in couples with normal TVE finding, 10 of them conceived after IUI and 24 women after IVF. There was also no spontaneous conception in women with endometriosis detected, but only 4 of them conceived after IUI, all remaining (18) after IVF. In the group with tubal infertility ("subclinical" periadnexal adhesions) 6 of them (33%) conceived spontaneously, two couples conceived after IUI and 10 couples after IVF.
Conclusions: In our experience in women with "subclinical" periadnexal adhesions the chance for spontaneous conception was quite high while no woman with "minimal" endometriosis conceived spontaneously in our group. However, before practical recommendations can be made more studies are needed to draw final conclusions.

P-35

The role of sonohysterography in infertile women

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Introduction:
In literature there is still many controversion about usefulness of sonohysterography (SHG) in diagnostic of infertility.
Aim: The aim of this study was to identify the role of SHG in infertile women.
Materials and methods:
A total of 76 infertile women were included in this study. Patients were randomized into two groups: Group I-consisted of 38 women who underwent SHG to asses etiology of infertility, Group II-consisted of 38 women who underwent diagnostic laparoscopic and hysteroscopic surgery. Comparison of SHG with laparoscopic and hysteroscopic surgery was conducted.
Results:
Based on SHG and laparoscopic and hysteroscopic surgery the same following pathologies were diagnosed: 9 cases of occlusion of oviduct, 5 endometrial polyps, 4 submucous myomas and 2 abnormalities in the uterine cavity. In the rest cases there were no anatomical pathology. SHG had the same effectiveness as laparoscopic and hysteroscopic surgery

in diagnosing female reproductive organ pathology. The mean time of SHG was significantly shorter than laparoscopic and hysteroscopic surgery. SHG was possible to perform in outpatients department. Patients recovery was faster after SHG than after endoscopic procedures. SHG procedure was cheaper than endoscopic procedures. Both SHG and endoscopic procedures requested administration of antibiotics and analgesic drugs. Laparoscopic surgery was better to diagnose adesions inside pelvis and ovaries pathologies.
Conclusions:
1. Sonohysterography with saline solution should be efficiently used in outpatients departments as a first way for detection of endometrial cavity pathology and occlusion of oviducts.
SHG is the best way to check up patency of oviducts in outpatients department.

P-36

Mammary Ductoscopy. Comparison of images
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Introduction
For the study of the intraductal pathology the image techniques give us indirect information, the ductoscopy is a technique by which we can visualize directly the mammary ducts using a microendoscope connected to a video camera with image amplification.
Matherial and methods
We use two types of endoscope: a diagnostic one, smaller and a surgical one with work channel. It is an ambulatory technique that allows a direct visualization of the ducts, washings for cytological analisys, cytological brush, biopsies and microsurgery. We can have an exact location of the lesion previous to the surgery
There are a series of normal characteristic images as much as of the intraductal pathology, ductal ectasia, papilloma, inflammation, carcinoma, etc.
Conclusions
The ductoscopy is a technique which allows us the direct study of the mammary duct, with an exact location of the lesions, assuring the diagnosis for a surgery with smaller tissue aggression.

P-37

Essure® Hysteroscopic Sterilization-Initial Experience
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Objective:to ascertain the success rate, complications and patient acceptability of this new procedure being performed in our unit.
Method:After appropriate counselling, hysteroscopic sterilization is performed in the outpatient hysteroscopy clinic. Follow-up by telephone contact is arranged after 48hours. Abdominal X-ray is routinely performed after 3 months to check device placement. Hysterosalpingogram is requested if the X-ray is inconclusive or if there is increased risk of perforation. The details of all the procedures performed are kept on a database which was analyzed retrospectively.
Results:Hysteroscopic sterilization was introduced in our unit in November 2002. 36 procedures were carried out using the older devices with successful bilateral placement in 77% of cases. 1 patient passed a device pv 5 months following the procedure, and later underwent a repeat placement with successful bilateral tubal block.There were 2 cases of perforation, and the devices were removed laparoscopically. Since April 2004, an additional 136 procedures have been performed using modified devices. Successful bilateral placement of devices was achieved in 94% of cases. In 4 patients, only 1 device was placed; 3 due to pre-existing tubal block and in 1 because of previous salpingectomy. 116 patients have had imaging confirming device placement. The remaining 20 patients are either awaiting appointments or failed to keep their appointments.1 patient was pregnant at the time of the procedure which was done during the luteal phase of the cycle. Pregnancy test at the time was negative. In 6 patients additional procedures were performed at the same time; thermachoice endometrial ablation in 4 and polypectomy in the other 2.The majority of women were satisfied with the procedure and the care they received.
Conclusion:Essure hysteroscopic sterilization is a safe and simple procedure with high success rates and high patient acceptability.

P-38

Abstract: Bilateral cornual abscess after endometrial ablation following Essure® sterilization
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Endometrial ablation is performed extensively to treat dysfunctional bleeding. Since the introduction of Essure® tubal sterilization the use of this permanent contraception method is spreading rapidly worldwide. The endometrial ablation as well as the Essure® sterilization are procedures

of which only few complications have been reported. We present a seriously infectious complication after an endometrial ablation in a patient with Essure® microinserts in situ. To our knowledge, this complication has not been reported before in patients with Essure® microinserts in situ. A feasibility and safety study on concomitant Essure® tubal sterilization and Thermachoice endometrial ablation has proven that these two treatments can be combined safely in a one-step approach. We think, that an asymptomatic endometritis, following the endometrial ablation in 5–7% of all patients, exacerbated and caused the abscesses due to presence of the foreign bodies of the Essure® microinserts. For this reason, we suggest to administer prophylactic antibiotics in case an endometrial ablation is performed in women with Essure® microinserts in situ or in women who will get the Essure® implants straight away after any kind of endometrial ablation.

TOPIC 10 : MISCELLANEOUS

P-40

Minimally invasive gynaecological surgery in alexithymic patients

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Objective: To investigate the prevalence of alexithymia, a particular personality trait characterised by disturbances of affect regulation and deficit in experiencing emotional life, and to examine the relationship between such disorder and self-reported descriptors of quality of life in patients submitted to minimally invasive gynaecological surgery. We hypothesise that alexithimic patients, with consideration of their peculiar cognitive style, should receive an attentive post-surgical follow-up.

Design and Methods: We enrolled 30 patients affected by a benign gynaecological pathology and elegible for either diagnostic/operative hysteroscopy or urinary incontinence correction. By means of a semi-structured interview, we collected personal, medical and social data of all patients. They were also provided with a set of questionnaires designed to measure both the level of alexithymia (TAS-20) and the perception of quality of life (The Medical Outcomes Study short-form general health survey-36, known as the SF-36). They were assessed before the surgical procedure and at 1 and 3 months after the surgical treatment.

Results: According to the TAS-20 median score, the patients were divided into two groups: the high-level alexithymia group (HA) and the low-level alexithymia group (LA). Our data reveals that the subjective quality of life tested with SF36 is clearly influenced by the level of alexithymia.

Conclusions: As a consequence of a worse perception of their quality of life, alexithymic patients should receive a close follow up in their post-operatory period.

P-41

Early complications in patients with pelvic organs prolapse following surgery with the use of the Prolift system–preliminary report

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The analysis included 65 procedures performed in patients with pelvic organs prolapse using the Prolift Pelvic Floor Repair System (Gynecare). The mean age of patients was 63 years (range 34–83). The mean BMI value 28 kg/m^2 (20–38). 59 treated patients (91%) had vaginal labour, with 66% reporting 2 or 3 deliveries, while 6% reported above 4 births. The average parity was 2 (0–5). Approximately 25% of patients (16) complained of a mixed urinary incontinence, 22% (14) showed evidence of stress urinary incontinence, while 15% of patients reported urge incontinence 15 % (10). 15% of all patients reported previous hysterectomy, and 21% reported vaginal wall plasty. The prolapse grade was assessed using the POPQ scale. Over half of the patients (54%) were classified as grade III, 37% were evaluated to have grade II, while 9% of patients were found to have grade IV. 65% of treated patients (42) underwent repair surgery using the anterior Prolift set, with 5 patients (7,7%) undergoing simultaneous vaginal hysterectomy, while 14 (21,5%) underwent simultaneous posterior vaginal wall plasty. Surgery using the posterior Prolift set was performed in 12 patients, while 11 other patients (17%) underwent Prolift Total pelvic floor repair, with 3 cases (4,6%) of simultaneous vaginal hysterectomy. The mean surgery duration of the "anterior Prolift" procedure was 48 minutes (30–75), 57 minutes (45–75) for "posterior Prolift", and 86 minutes (65–120) for total Prolift". The average intra-operative blood loss was evaluated to be 180 ml (50–500) for "anterior Prolift", approx. 170 ml (50–300) for "posterior Prolift", similarly to "total Prolift", also approx. 170 ml (30–300). Early complications were observed in 9,2% of all treated patients (6). There was 1 case (2,4%) of vaginal bleeding requiring additional surgical proceeding following "anterior Prolift", and 2 cases (4,8%) of subvesical haematoma evacuated without need for mesh

removal. Vaginal bleeding was also observed in 1 patient (8,3%) following "posterior Prolift" surgery. As concerns patients subject to "total Prolift" surgery, complications were observed in 2 cases (18%). One patient experienced vaginal bleeding requiring additional sutures. In the second case, a haematoma of approx. 1000 ml formed in the Retzius space, requiring laparotomy management and drainage.
All the treated patients are followed up to further assess the "Prolift" system efficacy.

TOPIC 11 : REPRODUCTIVE SURGERY

P-42

Transvaginal endoscopy in the investigation of the infertile couple

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Objective: The objective of this study is to evaluate the feasibility and acceptability of transvaginal endoscopy based approach, in One Stop infertility investigation.
Design and Methods: We present a prospective observational study. Infertility investigation involved interview with a couple, review of blood and semen analysis, pelvic ultrasound, diagnostic hysteroscopy and tranvaginal laparoscopy (TVL). Outcome measures were feasibility of investigations, findings, evaluation of a management plan.
Results: 70 couples met our selection criteria and attended the investigation. Hysteroscopy was successfully done in all cases, and in 91% of cases, pathology was treated in the same procedure. TVL failed in 8 women. The first five failures were in the first 25 procedures. We had two extraperitoneal bowel perforations, both were examined with laparoscopy immediately and severe endometriosis was found. After the reevaluation, the endometriosis could have been suspected but was overlooked and is considered as a part of a learning curve. The surgical treatment (laparoscopy) was suggested in 32% of women whom were found to have pelvic pathology. The investigation was well tolerated and all patients left the hospital 2–3 hours after the procedure. There were no readmissions.
Conclusion: The use of TVE in the infertility investigation is well tolerated, feasible but not suitable for all couples. Some laparoscopies are avoided and length of time needed for infertility investigation is considerable shortened.

P-43

Laparoscopic ovarian drilling as a treatment in young adult women with polycystic ovarian syndrome resisant to clomiphene citrate therapy

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Objective: To evaluate the changes in serum hormone levels, the normalisation of the menstrual cycle and the effect on pregnancy rates, after laparoscopic ovarian drilling (LOD) in young adult women with polycystic ovary syndrome (PCOS).
Design: Prospective nonrandomized study in a teaching hospital.
Material and Methods: From December 2001 through March 2004, twenty selected patients with PCOS resistant to clomiphene citrate, included in the study. The hormonal effects (insulin, fasting blood sugar, insulin-like growth factor-1 (IGF-1), prolactine (PRL), inhibin-A, sex hormone-binding globulin (SHBG), total testosterone, follicle stimulating hormone (FSH), luteinizing hormone (LH), FSH/LH, DHEA-S, D4 androstendione) were measured before and after three months from laparoscopic ovarian drilling in the early follicular phase Also, the menstrual pattern, and reproductive history were documented in a six month follow-up period.
Results: Levels of serum FSH, PRL and SHBG did not influence significantly but IGF-1 and insulin levels were significantly higher three months after LOD. Also, there were significant decreases in insoulin, LH, total testosterone, DHEA-S, D4 androstendione serum levels and in LH/FSH ratio. In the follow-up period, 65% of the subjects were recorded to have regular cycles and 55% pregnancy rate was achieved, spontaneously.
Conclusion: Treatment of young adult women with PCOS resistant to clomiphene citrate with LOD, reduced significantly insoulin, androgen, LH levels and LH/FSH ratio, but did not influence FSH, PRL and SHBG levels during short-term follow-up. Laparoscopic ovarian drilling may be beneficial to endocrine profile of patients with PCOS. It seems to normalise the menstrual pattern and to increase the chance of spontaneous conception in these patients for a short-term follow-up period.
Keywords: Laparoscopic ovarian drilling, polycystic ovarian syndrome, hormonal profile.

P-44

Hysteroscopic myomectomy as a successful technique in reproductive surgery

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Objectives: The aim of this study was to determine fertility rates in infertile women after hysteroscopic myomectomy.
Materials and Methods: Thirty-six infertile woman were included, primary infertility in 24 (67%) patients, secondary-in 12 (33%), mean (±SD) age was 28,8±4,6 years. The mean myoma size was 32±12 mm, intracavitary myomas in 10 (27,8%), intramural Class I in 22 (61,1%), and Class II in 4 cases (11,1%). The myomectomy was performed by common technique using monopolar resectoscopy in 5D solution, infused by a hysteropump, with mean operating time 27±12 minutes.
Results: Viable pregnancy and live births achieved after hysteroscopic myoma resection in 26 cases (72%). Combined perinatal loss was 8%, due to two early abortions. Pregnancy was complicated by early gestosis in 10 patients (38,5%), uterine cramping in 4 (15,4%) and first-trimester vaginal bleeding in 3 (11,5%), placental insufficiency in 10 (38,5%), which led to IUGR in 2 (7,7%) cases, anemia in 16 (61,5%), pre-eclampsia in 8 (30,8%), preterm rupture of membranes in 7 (26,9%) woman. Cesarean section was performed in 15 cases (57,7%). At the same time, there were no risk of uterine rupture in labour. Mean infant weight was 3416±184 grams and mean height 52,4± 1,2 cm, which does not statistically differ from means in population.
Conclusions: Increased frequency of the first-trimester threatened abortion may be due to changes in vascular bed of uterine wall after the resectoscopy, but it is successfully managed by standard diagnostic and treatment protocols. Hysteroscopic myomectomy allows for subsequent vaginal labor and could be considered as a successful reproductive technology in women with submucous myoma.

P-45

Hysteroscopy In Infertile Patients To Evaluate The Quality Of The Endometrium

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Introduction: The aim of this study was to describe the quality of the endometrium and to determinate if the use of the Sakumoto-Masamoto classification (1+2), to describe the mid-secretory endometrium at hysteroscopy is a useful tool to analyze the pregnancy outcome after implantation.
Methods: 138 infertile patients with a median age of 37.0 years (range 31–42) were included in this study. All patients had a preoperative transvaginal sonography (TVS) and a hysteroscopy in the second part of the menstrual cycle to evaluate the intrauterine cavity and the quality of the endometrium. The surgeon was blinded to the TVS-findings. The endometrial surface was evaluated according to the Sakumoto-Masamoto classification ("good" vs. "poor"). Endometrial biopsy and hysteroscopic procedures were carried out when indicated. The following diagnosis were considered separately: polypoid lesions, intrauterine adhesions and endometrial hyperplasia. The patients were analysed retrospectively in order to find a possible relationship between the quality of the endometrium and the pregnancy rate (spontaneous pregnancy, intrauterine insemination by husband and IVF/embryo transfer). For statistical purpose a Fisher exact test was used.
Results: 88 patients (63.8%) were classified endoscopically as having "good" mid-secretory endometrium and 50 patients (36.2%) as "poor". There were no differences in the distribution pattern of the infertility causes between the two groups, the age of the patients and the delay of the infertility. The overall pregnancy rate was 38.4% (53 patients): a "good" endometrium was found in 38 patients (71.7%) vs. 15 patients (28%) in the "poor" group ($p<0.05$). Furthermore we found by hysteroscopy 31 (22.5%) patients with polypoid lesions vs. 12 (8.7%) in TVS ($p<0.001$). In 9 patients uterine malformations (6.5%), vs. 5 (3.6%) by TVS (n.s.), adhesions were found also in 5 patients.
Discussion: Our data suggests that the hysteroscopic appearance of the mid-secretory endometrium in infertile patients could be a useful parameter to evaluate the success rate of a fertility therapy. Our results confirm also the highly significant superiority of the hysteroscopy concerning the sensitivity and specificity of diagnosis of intrauterine pathologies compared to the ultrasonography.
References: (1) Sakumoto T., Horm Res. 1992; (2) Masamoto H., Hum Reprod. 2000.

P-46

The introduction of fertiloscopy (transvaginal hydrolaparoscopy) in North-east Romania. An initial clinical experience

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Fertiloscopy emerged in the last decade as an option to diagnostic laparoscopy, especially in infertility cases. In Romania the technique has been very rarely used, and in our region it has not been performed until April 2007. We present here our first 5 cases, realized partially with the help of an expert from Lyon, France.
Material and methods. All of our cases were referred for infertility, and have had previous hysterosalpingography, ultrasound-and sometimes previous hysteroscopy. The fertiloscopy was performed as described by dr. Watrelot, using a 2.7 mm telescope, the fertiloscopy kit, and dystension by serum chloride. Hysteroscopy and blue dye test were also included in all of our cases. Anaesthesia was IV short term opioid mixture, and in 2 cases with local paracervical block.
Results: From our cases, 2 were performed by the invited expert, and the rest by local laparoscopists. The ovaries, tubes and posterior side of the uterus were visualised in all cases. No incident was noted, and in all cases the patients were able to be dismissed between 8–24 hours, with no further complications.The pathology described included: PCOS, one unilateral tubal obstruction, intrauterine polyp, and the rest of cases were considered normal.
In conclusion, we consider this method of "fertiloscopy" appropriate for infertility patients, especially as it allows one day-laparoscopic surgery and has a fast learning curve. Further use of the method will allow us to find more advantages and disadvantages of the method, and propose technical developments towards minor surgery procedures.

TOPIC 12 : UROGYNECOLOGY

p-47

Laparoscopic colposuspension-is there still place for it?

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Objectives: To analyze long-term success of laparoscopic colposuspension in the treatment of stress urinary incontinence (SUI).
Materials and methods: In the period from November 2000 to the end of 2004, 29 patients underwent laparoscopic colposuspension due to SUI. The mean age of the patients was 43 years. In all patients SUI was previously confirmed by clinical examination, "one-hour" pad testing and multichannel urodynamic measurements. Transperitoneal approach with prolene mesh and rotary clips for vaginal fixation to the Cooper's ligament was the implemented surgical technique.
Two years after operation the success of the treatment was evaluated by clinical examination, "one-hour" pad test, and "stress test" in upright position. The patients were considered cured if there was no leakage on stress test and if "one-hour" pad test was also negative. Any leakage during stress testing was considered as a failure. The patients with negative stress test, but positive "one-hour" pad test, were considered as "improved".
Results: Two years after operation 9 patients (30%) were stress incontinent again, and additional 6 patients (20%) were considered as "improved" only. Overall patients satisfaction with the operation was 55%.
Conclusion: Long term effectiveness (2 years) of laparoscopic colposuspension in this study was comparable with the results published in previous studies. Bearing in mind that the efficiency of artificial sling procedures after 5 years is not greater than 60%, we consider laparoscopic colposuspension acceptable treatment for SUI, when two-fold indication for laparoscopic procedure exists (i.e. SUI and uterine myomas, SUI and ovarian cysts...).

P-48

Long-term results of transvaginal Burch operation for stress urinary incontinence: 5 year experience

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Objective: To demonstrate our 5 year experience and results with previously defined new retropubic suspension operation of stress urinary loss for transvaginal Burch operation.
Study Design: A prospective study of patients that were operated by transvaginal Burch operation for stress incontinence in 5 years time. All patients were reevaluated for stress urinary loss 6 months after the surgery.
Results: 231 patients have been operated by new retropubic suspension operation of stress urinary loss; transvaginal Burch operation. Mean age of the patients was 42 years (27–79). Mean duration of follow-up for patients after operation was 30 months (8–48 months). All patients were evaluated for stress incontinence in history, pelvic examination and with urodynamic investigations before operation. All patients were also reevaluated for these measures 6 months after operation. There were 44 patients with previous history of gynecologic operation (19%). We have detected 205 (88.7%) patients with genuine stress incontinence, 26 (11.3%) patients with combined stress incontinence (with also detrusor instability). *During follow-up period*, in *215 (93%) patients, we have observed complete remission for stress urinary loss. In 5 patients (2.1%) we came across with genuine stress incontinence and in the remaining 11 patients (4.7%) detrusor instability was detected. We did not come across with any important complications related to the procedure in any patients.*

Conclusion: There are hopeful and satisfactory results of our technique in patients that were diagnosed as stress incontinence. This method also shortens the duration of operation considerably and is highly comfortable for the patients.
Key Words: Stress urinary incontinence, Transvaginal Burch operation, Long-term results.

P-49

Vaginal surgery with mesh in treatment of the vaginal prolapse in our hospital

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INTRODUCTION: - The objective of this communication is to inform about our results with the techniques of mesh in the correction of the genital prolapse in the woman.
We have made the correction of the genital prolapse present in the woman with different current devices present in the market. The period go from July of the 2.004 to March of the 2.007.
The different devices have considered to value the best adaptation to our characteristics.
METHOD. - The selected patients are those that go to the consultation of pelvic floor pathology of the Hospital de La Ribera (Alzira-Valencia). The patients are derived for the general doctors or other consultations of hospital.
We are collected all the interventions made for correction of genital prolapse, as much anterior as posterior compartment or both. Also we are taken if associated to vaginal histerectomy. The association to techniques of correction of urinary incontinence has not considered.
In 2.004 we are performed 8 procedures about posterior compartment, with vaginal histerectomy 1 and 7 vault prolapse. In 2.005 we are performed 59 procedures, posterior compartment 25 and anterior compartment 34, with vaginal histerectomy 18, conserving uterus 21 and in vaulta prolapse 20. In 2.006 we are maked 80 procedures, posterior compartment 47 and anterior compartment 33, with vaginal histerectomy 45, conserving uterus 14 and vault prolapse 21. In 2.007 up to 31 of March we have made 21 procedures, posterior compartment 11 and anterior compartment 10, with vaginal histerectomy 10, conserving uterus 4 and vault prolapse 7.
Altogether, are gathered 168 procedures from July of the 2.004 to March of the 2.007.
RESULTS. - According to our protocol we have gathered intraoperating, postoperating the complications immediate (first week), postoperating to the first month.

INTRAOPERATIVE COMPLICATIONS	
Vesical injuries	3 (1,8%)
Rectal injuries	0
Hemorrhages	3 (1,8%)
Short term COMPLICATIONS (1[a] WEEK)	
Pelvic Hematoma	3 (1.8%)
Buttock Hematoma	15 (8.9%)
POSTOPERATIVE COMPLICATIONS (1° MONTH)	
A) VAGINAL EXPOSITIONS	ANTERIOR 3 (1.8%)
	POSTERIOR 4 (2.4%)
B) PELVIC PAIN	7 (4.2%)
C) RECURRENCE PROLAPSE	COMPARTMENT NONTREATED 2 (1.2%)
	FAILURE PROCEDURE 1 (0.6%)
D) URINARY INCONTINENCE	SUI (REQUIRED SURGERY TREATMENT) 2 (1.2%)
	URGE INCONTINENCE *NEW* 7 (4.2%)
	URGE INCONTINENCE PREVIOUS 20 (11.9%)
E) GRANULOMAS	7 (4,2%)

DISCUSSION. - All we agree in which many studies affluent designed make lack to draw conclusions in the long term. We have follow-up of up to 30 months. In general, the results are good. The complications are not serious and usually are solved with local and ambulatory treatment, except those of new appearance like the stress urinary incontinence that have not appeared in previous the urodinamic study to the operation and the recurrences of prolapse of the compartment nontreated by diagnosis failure and of the vault prolapse by technique failure.