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Best Selected Oral 1

Comparison of Fiber-Free Diet and Mechanical Bowel Preparation in Laparoscopic Hysterectomy Preparation

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Background

Our study was designed to elucidate bowel preparation in laparoscopic hysterectomy planning, as an effort to provide evidence-based recommendations in the light of quantitative data.

Methods

A prospective, randomised, controlled trial was conducted, including 138 patients, undergoing laparoscopic hysterectomy for benign reasons between 2021 and 2023. Patients were randomised into two groups: preoperative fibre-free diet for 3 days and MBP.

Hysterectomy due to malignancy, endometriosis, presence of gastrointestinal disorder and history of gastrointestinal surgery, need for postoperative intensive care unit (ICU) admissions were excluded. Aside from the bowel preparation method, management was planned uniformly. Demographics, physical examination findings and laboratory values were noted. Dilation, fullness and overall mean screen coverage of intestines during surgery were assessed. Postoperative symptoms, mobilisation time, catheter duration, pain scores, analgesic needs, satisfaction rates and hospital stay lengths were evaluated. Postoperative care was planned in accordance with the Enhanced Recovery After Surgery protocols.

Results

Demographics were similar (all $p>0.05$). The fibre-free diet group demonstrated significantly less bowel dilation (8.6% vs. 23.5%, $p=0.01$) and better surgical visualization ($p<0.05$).

94,2% of patients in diet group had less than half of screen coverage by bowel and intestines whereas in MBP group this rate was 79,4% ($p<0.05$).

Pain scores were similar ($p>0,05$). Diet group gained mobility earlier ($p=0,001$).

First passage of flatus was slower in MBP group ($p >0.05$). First defecation faster in MBP group ($p>0.05$). Although not statistically significant, the diet group was observed to pass flatus earlier but have a later stool passage.

Nausea, vomiting and antiemetic were similar ($p>0,05$). Both groups had similar stool passage weekly peri-operatively ($p>0.05$). Complication rates were similar ($p>0.05$).

Diet group delivered higher satisfaction scores (8,1 vs 7,7) and higher compliance (96% vs 82%), than MBP group (both $p=0.01$).

Fiber-free diet reduced preparation expenses by $\approx 15\%$, primarily due to decreased reliance on medical staff.

Conclusions

By significantly minimizing bowel dilation and improving intraoperative visualization, fibre-free diet contributes to a more seamless surgical experience.

Faster postoperative mobilization in diet group reflects enhanced recovery, reduced discomfort, and decrease in hospital stay. The fibre-free diet group reported significantly higher satisfaction scores; mental well-being and self-perception are known to have a positive impact on postoperative recovery, satisfaction with the surgical process can also accelerate healing (11).

The single-centre design may limit the generalizability of the findings. The sample size within particularly the BMI $< 25 \text{ kg/m}^2$ group, was relatively small, which may affect statistical power. Integrating objective imaging techniques of surgical visualization evaluation could further substantiate the findings.

Fiber-free diet emerges as a clinically superior, cost-effective and patient-centred alternative to MBP in laparoscopic hysterectomy. Its adoption could enhance surgical outcomes and overall patient satisfaction. Future multicentre and diverse population studies are recommended for exploring applicability across surgical disciplines, ensuring integration into global practices.

Annual audit of conservative management of atypical endometrial hyperplasia at a UK tertiary centre: are we meeting the national standards?

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Background

Atypical endometrial hyperplasia poses a substantial risk of progression to endometrial cancer. In patients choosing conservative management, regular endometrial biopsies are essential to monitor disease progression or regression. Adherence to surveillance guidelines ensures early detection of malignant change, supporting timely intervention and improving patient safety and long-term outcomes.

This audit aim to evaluate the conservative management of atypical endometrial hyperplasia at a tertiary gynaecology centre in the UK against the Royal College of Obstetricians and Gynaecologists (RCOG) Green-top Guideline No. 67, focusing on adherence to surveillance intervals and identifying areas for improvement.

Methods

A retrospective audit was conducted on histologically confirmed cases of atypical endometrial hyperplasia diagnosed between 1 August 2023 and 31 December 2024. Data were collected from electronic patient records. Exclusion criteria included concomitant diagnosis of endometrial cancer, pregnancy following the index biopsy, or death from unrelated medical conditions. Patient demographics, surveillance intervals, and biopsy outcomes were recorded.

Results

A total of 119 patients were identified. After applying exclusion criteria, 102 patients were included, of whom 44 (43%) opted for conservative management with Mirena intrauterine device or oral progesterone. The average age was 42 years, and the mean BMI was 42. Among these 44 patients, 38 (86%) were offered surveillance biopsy within 3–6 months, 4 (9%) within 7–9 months; 2 patients (5%) did not attend scheduled appointments.

Thirty-nine patients underwent a second biopsy: 34 (87%) had it within 3–6 months, 4 (10%) within 7–9 months, and 1 (3%) at 12+ months. Thirteen patients achieved histological regression of disease. Of these, 6 (46%) were offered 6–12 monthly surveillance, 1 patient had persistent disease and proceeded to hysterectomy, 2 had hysterectomy to avoid repeat biopsies, and 4 were not yet due for follow-up.

Conclusions

The audit highlights good adherence to recommended surveillance intervals in patients undergoing conservative management of atypical hyperplasia, with improved consistency compared to previous years' audit. This improvement appears to correlate with the recent introduction of a multidisciplinary team (MDT) tracker, which has strengthened follow-up pathway. Rising BMI remains a notable concern, both as a modifiable risk factor and a contributor to surgical risk. The future plan would be to establish pathway to offer women glucagon-like peptide agonists via an MDT with endocrinologist input to optimise long-term outcomes.

Cavaterm® endometrial ablation under local anaesthesia in an outpatient setting: a pilot study

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Background

Cavaterm® (Veldana Medical©, Switzerland) is a minimally invasive endometrial ablation system for dysfunctional uterine bleeding. Its use in an outpatient setting under local anaesthesia has not previously been investigated. This prospective study was conducted to determine its efficacy and technical feasibility under local anaesthesia in the outpatient setting.

Methods

The study included 20 consecutive women with heavy menstrual bleeding unresponsive to medical management. Before and after the procedure, one Ketoprofen tablet (100 mg) was given. Local anaesthesia protocol consisted of using both paracervical and intrauterine fundal blocks. An endometrial biopsy was always performed followed by the insertion of the Cavaterm® device into uterine cavity and application of circulating heat and pressure in the balloon catheter during 10 minutes. The device was then removed. Primary outcomes included assessment of pain using continuous (VAS) and ordinal scales (Modified McGill Pain Questionnaire), menstrual bleeding questionnaire (pictorial blood loss assessment chart PBAC score), and the Patient Global Improvement (PGI) score (a specific surgical satisfaction questionnaire). Health related quality of life (HRQL) was the secondary outcome measured by the Short Form 12 (SF-12).

Results

The mean pain scores (assessed by a visual analogue scale) during the procedure, at 60 min, 120 min and 24 hours post-operative were respectively 2.15 (0-6), 2.36 (1-7), 2.21 (1-6) and 2.0 (0-8), all classified as mild pain. All patients were discharged home the same day. At follow-up, there was a significant improvement in quality of life especially in the physical health aspect of the SF-12 (42.3 vs 55.9 at 6 months, $p < 0.02$). as well as global pain assessment at 6 months ($p = 0.01$). The PGI score was 1.0 (1-2) at 6 months. The PBAC score significantly decreased from 760.0 to 6.0 (0-60) at 6 months ($p = 0.008$). Successful reduction in bleeding occurred in 90% (18/20) of the patients by 6 months: at the 6-month follow-up, the amenorrhea rate was 30% (6/20) and 12 participants (60%) experienced reduced menstrual blood flow. Only 2 (10%) patients reported menorrhagia at 6 months.

Conclusions

Cavaterm® endometrial ablation performed under local anaesthesia in an outpatient setting is a quick, safe and effective treatment for dysfunctional uterine bleeding. The procedure was well-tolerated, with mild pain reported and led to significant improvement in bleeding symptoms, patient satisfaction and quality of life. procedure under local anaesthesia.

Are there differences in localization and type of adenomyosis in patients with reproductive failure compared to those with live born pregnancy?

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Background

The aim of this study was to evaluate the association of the precise localization, type and severity of adenomyosis in patients with different the reproductive outcomes. In particular we compared patients with adenomyosis and repeated implantation failure (RIF) during ART, to those with recurrent pregnancy loss (RPL) and at least one live birth (LB).

Methods

This retrospective observational study, included patients admitted to Gynaecological Ultrasound Unit of the University of Rome "Tor Vergata", Italy, between March 2020 and March 2025. All patients suffered from adenomyosis diagnosed through 2D, 3D and Power-Doppler (PD) transvaginal (TVS) examination in order to evaluate accurately the localization (internal and/or external myometrium), type (focal, diffuse, mixed) and the severity (mild, moderate, severe) of adenomyosis. The diagnosis of adenomyosis was performed with the presence of at least one direct sign based on current Morphological Uterus Sonographic Assessment (MUSA) classification. The ultrasonographic diagnosis was performed before the pregnancy (LB group), shortly after the miscarriages (RPL group) and the implantation failures during the IVF treatment (RIF group). Regarding the RPL and RIF group all known endocrinological and immunological causes were excluded. Only euploid embryos or embryos obtained by egg donation were included in RIF group.

Results

70 patients with adenomyosis were included for each group considered : RIF, RPL and at least one LB. Among these groups the different position of adenomyosis was investigated dividing in only and total inner myometrial, only external and mixed one. A statistically higher presence of only outer myometrium was seen in the LB group (70%) compared to RIF (45.7%) and RPL (35.7%) group ($p=0.0037$, $p=0.0001$ respectively). In particular, the presence of total inner, diffuse and severe adenomyosis was observed statistically higher in the group with RIF ($p=0.0037$, $p<0.0001$, $p=0.0003$, respectively) and RPL ($p=0.0001$, $p<0.0001$, $p=0.0012$, respectively) compared to LB. The presence of adenomyosis associated to endometriosis, specifically endometriomas ($p=0.0039$), was significantly higher in the RIF (48.6%) population compared to RPL(25%). While the presence of only adenomyosis without endometriosis was significantly higher in the patients with RPL compared to RIF ones ($p=0.0270$).

Conclusions

Adenomyosis is linked to poor reproductive outcomes through mechanisms that remain incompletely understood. Our study demonstrated a strong association of the presence of adenomyosis, in particular the inner myometrial involvement, in the RPL and RIF group compared to LB group.

Whereas the presence of adenomyosis affected only the outer myometrium is more presented in patients without reproductive failure and a live born birth.

Pelvic ultrasound findings in Adolescents: a comprehensive photographic overview of 3 years

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Background

The aim of the study is to provide an overview of pelvic pathologies in adolescents (12-20 years old) through specific ultrasonographic (US) findings, evaluating the prevalence of the most common conditions and the associated clinical symptoms referred by the young girls.

Methods

In this retrospective observational study we included 404 adolescents, aged 12–20 years old, who underwent between January 2022 and January 2025 a pelvic US examination in our Gynaecological Ultrasound Unit. In order to evaluate certain US findings, we excluded adolescents who underwent only transabdominal US including only those who were examined transvaginally or transrectally (in pre-sexually active girls). We stratified the data by age in early, middle and late adolescents. Medical history and their symptoms, including dysmenorrhea, heavy menstrual bleeding (HMB) and irregular menstrual cycles, routinely collected prior each scan, were evaluated and correlated to the US findings.

Results

The study population of 404 adolescent girls was stratified into early adolescence (12–14 years) 22 cases (5.5%), middle (15–17 years) 144 patients (35.6%), and late adolescence (18–20 years) 238 cases (58.9%). Normal ultrasound findings were observed in 55.2% overall, highest in early adolescents (81.8%), followed by middle (57.6%) and late (51.3%) groups. Pathological findings increased with age reaching 18.2% in early, 42.4% in middle, and 48.7% in late adolescents. The prevalence of endometriosis/adenomyosis was 31.6% (128/404), significantly less frequent in the 12–14 group compared to middle and late adolescents ($p < 0.05$). Posterior deep infiltrating endometriosis (DIE) including uterosacral ligament (USL) and torus fibrosis thickening were absent in early adolescents and more frequent in older (15–20 years) groups ($p < 0.01$). Endometriomas were significantly more frequent in late adolescents compared to middle ones ($p = 0.03$). Congenital uterine anomalies were more prevalent in the 18–20 group compared to the 15–17 group (7.3% vs 1.4%, $p = 0.01$), with partial septate uterus being the most common (3%). Polycystic ovarian morphology (PCOM) and adnexal lesions were found in 6.3% and mainly in older patients (6.1%). Fibroids (1.3%) and endometrial polyps (0.2%) were rare and observed only in late adolescence. Dysmenorrhea and HMB were significantly associated with endometriosis/adenomyosis (38.7% and 39.5%), while menstrual irregularities were strongly associated with PCOM (98.2%).

Conclusions

Ultrasound evaluation plays a crucial role in identifying age-related gynaecological conditions in adolescents. In our cohort, the overall prevalence of pelvic pathologies increased with age, with endometriosis being the most prevalent. These findings highlight the importance of early ultrasound assessment in symptomatic adolescents, particularly in late adolescence.

Does the limit exist? Re-evaluating laparoscopic myomectomy thresholds for women with high-order fibroids in ethnic minority groups

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Background

To assess the outcomes of laparoscopic myomectomy in patients with high-order (>3) fibroids compared to open myomectomy, in order to establish the feasibility of minimally invasive myomectomy in women from ethnic minority groups.

Methods

This retrospective analysis was performed on real-time clinical data collected over an eight-year period at a single University Hospital in East London. A total of 79 patients who underwent myomectomy for high-order fibroids were included: 48 underwent laparoscopic myomectomy (LM) and 31 underwent open myomectomy (OM).

Primary outcomes included operative time, estimated blood loss (EBL), hospital stay duration, and blood transfusion rates. Demographic data, including ethnicity and the number of fibroids removed, were also collected. Statistical analysis included independent two-sample t-tests with unequal variances (Welch's t-test) for continuous variables and Fisher's exact test for categorical comparisons.

Results

Patients from black ethnic groups comprised the majority in both groups (77% OM; 81% LM). The mean number of fibroids removed was higher in the OM group (21.5; range 7–30) than in the LM group (14; range 10–22).

OM was associated with a significantly shorter operative time (134.5 vs. 156 minutes; mean difference –21.5 min, 95% CI: –36.4 to –6.6, $p = 0.0049$) which was in keeping with the technical complexity of laparoscopic myomectomy for this patient group. However, OM resulted in significantly poorer perioperative outcomes. Mean EBL was higher in the OM group (560 vs. 290 mL; difference +270 mL, 95% CI: 101.3 to 438.7, $p = 0.0026$), as was mean hospital stay (3.5 vs. 1.6 days; difference +1.9 days, 95% CI: 1.3 to 2.5, $p < 0.0001$). Blood transfusion rates were also significantly higher in the OM group (22% vs. 2%; $p = 0.0085$).

Conclusions

Patients from black ethnic minority groups are more likely to have high order fibroids. In most historical consensus statements, a laparoscopic approach is considered gold standard for up to three fibroids, resulting in exclusion of a higher proportion of ethnic minority women. This study demonstrates that with the right expertise, undergoing minimally invasive myomectomy leads to better surgical outcomes in women with high-order fibroids. Feasibility should not be determined by fibroid number, but rather by uterine size and surgical access. Minimally invasive myomectomy

should be made available to a wider group of patients and should be considered for women with greater than three fibroids. It is imperative that surgical training in the UK be standardised, such that women have equity of access to the required expertise and undergo surgery in the right place, at the right time, with the right surgeon.

Adenomyosis And Dysmorphic Uterus: Is There A Correlation? Analysis Of Reproductive Outcomes After Hysteroscopic Metroplasty

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Background

Hysteroscopic metroplasty has been shown to enhance reproductive success in women with dysmorphic uterus, but the impact of adenomyosis in these patients remains unclear. This study aims to assess the histological prevalence of adenomyosis and evaluate obstetric outcomes following corrective surgery in women with a dysmorphic uterus and a history of adverse pregnancy outcomes.

Methods

This retrospective, single-centre, observational study included 69 women diagnosed with a dysmorphic uterus and a history of infertility or pregnancy losses who underwent hysteroscopic metroplasty between January 2021 and January 2024 at the Digital Hysteroscopic Clinic, Class Hysteroscopy, Fondazione Policlinico A. Gemelli in Rome. The median follow-up period was 21 months. All included women underwent a one-stop diagnostic evaluation using 2D-3D transvaginal ultrasound and office hysteroscopy. Surgical correction was performed using a bipolar 15 Fr mini-resectoscope, involving the incision of the thickened uterine wall with a Collins loop and the excision of the redundant endomyometrial tissue. The prevalence of adenomyosis was assessed by ultrasound using Morphological Uterus Sonographic Assessment criteria and histologically through the evaluation of excised tissue. Additionally, the presence of other histological findings, were also investigated. Obstetrical outcomes, including clinical pregnancy rate (CPR), live birth rate (LBR), and miscarriage rate (MR), were analysed before and after metroplasty in two subgroups: recurrent pregnancy loss (RPL) and infertility or single miscarriage (ISM). Univariate binary logistic regression was used to evaluate the association between histological findings and LBR after metroplasty.

Results

Among 69 patients, 22 (32%) had a history of RPL and 47 (68%) had infertility or single miscarriage. Direct features of adenomyosis, according to MUSA ultrasound criteria, were observed in 49.3% of cases. The prevalence of histologically confirmed adenomyosis was significantly higher in the RPL subgroup (54%) compared to the ISM subgroup (28%, $p=0.03$). Following metroplasty, the overall CPR was 65%, with a significant increase in LBR per pregnancy from 0% preoperatively to 62% postoperatively ($p<0.01$). The MR decreased from 100% before surgery to 29% in the RPL subgroup ($p<0.05$). Among women with adenomyosis ($n=25$), CPR was 56% and LBR was 43%, lower than in the non-adenomyosis group (71%). Univariate analysis identified adenomyosis as a variable at the threshold of statistical significance for lower LBR, with $p=0.07$ and an odds ratio 0.31 (95% CI 0.08–

1.14). No significant associations with other histological or procedural variables were observed. No major obstetrical complications were reported.

Conclusions

Our findings indicate that adenomyosis may contribute to recurrent pregnancy loss and negatively affect post-metroplasty success rates, highlighting the need for individualized treatment approaches. While hysteroscopic metroplasty is a safe intervention for enhancing pregnancy outcomes in dysmorphic uterus patients, adenomyosis's presence requires further investigation to improve patient selection and treatment outcomes. Larger multicentre prospective studies and randomized controlled trials are required to confirm our results.

Obstetric and neonatal complications in pregnancies of women with histopathologically confirmed endometriosis, adenomyosis, or both: a national population-based cohort study

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Background

Endometriosis is a disease characterised by the presence of endometrium-like epithelium and/or stroma outside the uterus. Adenomyosis is an associated condition defined as endometrium-like tissue infiltrating into the myometrium. Recent studies suggest a relationship between endometriosis and adverse pregnancy outcomes, but evidence remains conflicting, especially regarding the potential added effect of adenomyosis.

Methods

We aimed to assess the prevalence of obstetric and neonatal complications in pregnancies of women with histopathologically confirmed endometriosis (EO), adenomyosis (AO), or both (EA), compared to the general Dutch obstetric population. We aimed to identify specific complication profiles associated with each phenotype.

This retrospective population-based study used two Dutch national databases (Perined and PALGA) to identify pregnancies in women with confirmed EO, AO, or EA. Outcomes were compared with those from the general Dutch obstetric population (n=4,065,165). We included 19,418 pregnancies with EO, 11,724 with AO, and 1,048 with EA. Multivariable logistic regression analyses were performed to calculate adjusted odds ratios (aORs) with 95% confidence intervals (CIs), adjusting for maternal age, parity, ethnicity, socioeconomic status, year of delivery, induction of labor, multiple gestation, hypertensive history, mode of conception, and delivery mode. A p-value of <0.05 was considered statistically significant.

Results

All three groups showed significantly increased risks for adverse outcomes versus the general population.

- **Placental disorders:** EO (aOR 1.17, CI 1.09–1.25), AO (aOR 1.21, CI 1.14–1.31), EA (aOR 1.44, CI 1.08–1.92)
- **Preterm birth:** EO (aOR 1.43, CI 1.37–1.46), AO (aOR 1.26, CI 1.19–1.34), EA (aOR 1.55, CI 1.30–1.86)
- **Caesarean delivery:** EO (aOR 2.73), AO (aOR 1.46), EA (aOR 2.51)

- **NICU admission:** EO (aOR 1.26), AO (aOR 1.09), EA (aOR 1.26)

Group-specific complications:

- **EO:** Increased risk of placental abruption (aOR 2.08), fetal distress (aOR 1.09), and perinatal death (aOR 1.34)
- **AO:** Increased risk of miscarriage (aOR 1.59), threatened prematurity (aOR 1.34), placental retention (aOR 1.20), preeclampsia (aOR 1.26), and postpartum haemorrhage (aOR 1.22)
- **EA:** Increased risk of placenta praevia (aOR 4.14) and endometritis (aOR 4.93)

No significant differences were found for dysmaturity, instrumental or spontaneous vaginal delivery.

Conclusions

Women with histologically confirmed endometriosis, adenomyosis, or both are at increased risk of adverse obstetric and neonatal outcomes, each with a distinct complication profile. These findings underscore the importance of recognising uterine phenotype in pregnancy risk assessment. Future research should explore the role of disease severity and evaluate preventative strategies.

Comparative Outcomes of Hugo™ Robotic and Laparoscopic Sacrocolpopexy in a High-Volume Tertiary Center: A Propensity-Matched Study

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Background

Minimally invasive sacrocolpopexy (SCP) is regarded as the gold standard procedure for treating Pelvic Organ Prolapse (POP) offering excellent anatomical and functional outcomes, superior success rates, and a lower risk of recurrence compared to alternative techniques. While it is feasible to perform SCP using conventional laparoscopic techniques, robotic-assisted surgery (RAS) represents an evolution of this procedure and has emerged as a solid alternative to laparoscopy. Recently, alternative platforms to the DaVinci® have been introduced in the market, including the Hugo RAS (MEDTRONIC Inc, USA), a system featuring multiple independent mobile bedside units and wristed instruments, aiming to enhance flexibility and distinguishing it from the monolithic structure of the DaVinci® system. The surgeon operates from an open console equipped with ergonomic controller handgrips, enhancing communication with the surgical team. The open console provides the surgeon with a three-dimensional, high-definition visualization. Although RAS is increasingly utilized for SCP and solid evidence proves its non-inferiority to laparoscopy, there is still limited evidence on the safety and feasibility of novel multi-arm robotic platforms compared to standard laparoscopic approach.

Methods

We conducted a retrospective study analysing prospectively collected data from 450 patients undergoing minimally invasive sacrocolpopexy between January 2022 and December 2023, using propensity score (PS) matching to correct for treatment selection bias. Primary aim was to analyse and compare the safety, feasibility, and outcomes of laparoscopic SCP procedure versus robotic-assisted surgery performed with the Hugo RAS system. After screening, demographic and clinical data from 420 patients with multicompartamental POP were collected. Propensity score case matching analysis generated two matched groups. After matching, 285 patients were compared, with 142 undergoing laparoscopic sacrocolpopexy and 143 undergoing robot-assisted surgery.

Results

Short to medium term outcomes were analysed and compared between the two groups. Our findings demonstrated that robotic-assisted surgery did not significantly differ from standard laparoscopic procedure in terms of intra- and post-operative complications, length of hospitalization, except for operative time and intraoperative blood loss (Table 1). Operative time was on average 15 minutes longer and intraoperative blood loss was slightly lower in the Hugo RAS population after matching. The mean follow-up was 18 months (range 12-36) and a statistically significant improvement of objective and subjective outcomes was reported in both populations, with a significant POP symptoms resolution and no difference between groups in term of satisfaction rate.

Table 1: Peri-operative data and post-operative outcomes.

Peri-operative data											
Variable	Unmatched population			Matched population							
	LPS (n=270)	Hugo RAS (n=150)	p-value	LPS (n=142)	Hugo RAS (n=143)	p-value					
OT (min), median (range)	135 (49-250)	150 (87-260)	<.001	135 (49-249)	150 (87-260)	.002					
EBL (mL), median (range)	20 (0-500)	30 (10-150)	.12	30 (0-500)	30 (10-150)	.002					
Time to discharge (days), median (range)	3 (2-4)	3 (2-5)	.87	3 (2-4)	3 (2-5)	.95					
Intraoperative complications, N (%)	9 (3.3)	8 (5.3)	.32	6 (4.2)	8 (5.6)	.60					
Postoperative complications, N (%)	10 (3.7)	7 (4.6)	.12	7 (4.9)	7 (4.9)	1.0					
Grade I	6 (60)	2 (29)		4 (57)	2 (29)						
Grade II	3 (30)	5 (71)		3 (43)	5 (71)						
Grade IIIa	0	0		0	0						
Grade IIIb	1 (10)	0		0	0						
Postoperative outcomes											
Variable	Unmatched population			Matched population							
	LPS (n=270)	Hugo RAS (n=150)	p-value	LPS (n=142)	Hugo RAS (n=143)	p-value					
Anatomical cure rate, n (%)	251 (93)	142 (94.7)	.50	132 (93)	136 (95.1)	.44					
Subjective cure rate, n (%)	260 (96.3)	147 (98)	.33	138 (97.2)	140 (97.9)	.70					
Stress urinary incontinence n, (%)	104 (38.5)	53 (35.3)	0.162	104 (38.5)	53 (35.3)	0.162					
PGI-I, n (%)			.39			.40					
1-2	263 (97.4)	148 (98.7)		138 (97.2)	141 (98.6)						
>2	7 (2.6)	2 (1.3)		4 (2.8)	2 (1.4)						
POP-Q Stage	Pre-op	Post-op	P-value	Preop	Postop	P-value					
Anterior POP-Q stage, median (range)	3 (1-4)	1 (0-3)	<.001	3 (1-4)	1 (0-3)	<.001	.13	3 (1-4)	1 (0-3)	<.001	.13
Apical POP-Q stage, median (range)	3 (2-4)	0 (0-2)	<.001	3 (2-4)	1 (0-2)	<.001	.29	3 (2-4)	0 (0-2)	<.001	.29
Posterior POP-Q stage, median (range)	1 (0-4)	0 (0-1)	<.001	1 (0-4)	0 (0-1)	<.001	.76	1 (0-4)	0 (0-1)	<.001	.76

Conclusions

Robotic-assisted SCP procedures performed with the Hugo RAS system appear to be safe and effective in treating symptomatic POP, representing a feasible alternative to laparoscopy. Our insights on this recently released robotic system may be useful for validating its use for urogynaecology and reconstructive pelvic surgery.

Transvaginal Natural Orifice Transluminal Endoscopic Surgery for Hysterectomy: Initial Insights from the Turkish Platform of Minimally Invasive Gynaecologic Surgery (TR-MIGS)

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Background

TR-MIGS Vnotes Group: Kemal GUNGORDUK, Yasam Kemal Akpak, Selcuk ERKILINC, Koray Görkem SARCINTI, Vakkas Korkmaz, Serhan Can ISCAN, Ahkam Goksel KANMAZ, Ghanim Khatib, Bahadır KOSAN, Candost HANEDAN, Salih TASKIN, Kemal OZERKAN, Cagatay TASKIRAN

Transvaginal NOTES (vNOTES) merges conventional vaginal surgery with laparoscopic single-port methods for addressing gynaecological conditions. When compared to standard laparoscopy, vNOTES may provide advantages such as less post-operative discomfort, faster recovery, shorter operation times, and improved cosmetic outcomes. This article focuses on sharing our early experience with implementing vNOTES across six gynaecological centres in Turkey, emphasizing its practicality, perioperative results, and safety considerations.

Methods

A retrospective study included all women who had undergone vNOTES hysterectomy, with or without salpingo-oophorectomy, for benign or malignant conditions. The surgical techniques for vNOTES hysterectomy were performed in accordance with the standardized protocol by Baekelandt et al. Baseline characteristics, along with data on intraoperative and postoperative surgical outcomes, were gathered and analysed.

Results

During the study period, a total of 685 patients underwent vNOTES. Of these, 64 patients (9.3%) had a history of having one caesarean section, 38 patients (5.5%) had undergone two prior caesarean sections, and 11 patients (1.6%) had experienced three or more caesarean sections. The primary surgical indications included myomas with or without metrorrhagia (53.0%), H-SIL or in situ cervical cancer (1.0%), endometrial hyperplasia or cancer (19.0%), adnexal masses (8.9%), and other conditions (18.1%). Additionally, a sentinel lymph node procedure was performed in 52 patients (7.6%). The average surgical duration was 72.4 ± 40.2 minutes, with a mean haemoglobin decrease of 1.4 ± 0.1 g/dL. The average uterine weight was recorded at 204 ± 145 grams. Intraoperative complications were identified in 1.7% of patients (n=12), while postoperative complications occurred in 1.4% (n=10). Six patients (0.9%) required conversion to conventional laparoscopy, which was mainly due to an obliterated pouch of Douglas and preoperative complications. The average hospital stay was 2.3 ± 1.4 days.

Conclusions

vNOTES has been demonstrated to be a viable and safe surgical method, addressing certain limitations associated with conventional laparoscopic and vaginal techniques for specific groups of women. Nonetheless, the study is not without its limitations, including a relatively small sample size and the lack of a comparative assessment. Moreover, it is important to highlight that all participating centres were specialized gynaecological surgery referral units, with procedures exclusively performed by surgeons highly skilled in both vaginal and laparoscopic methods. Future studies should prioritize assessing the learning curves of vNOTES among surgeons with varied levels of expertise. In spite of these shortcomings, the findings of this research provide valuable insights into the early implementation and practical use of vNOTES.

Complications and Management in Robotic Surgery

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Background

There are many applications and advantages of robotic surgery in gynaecology and gynaecologic oncology. However, it is also important to recognize and manage complications during robotic procedures. The aim of this report is to demonstrate various complications and their management during robotic surgery in our clinic.

Methods

In this presentation, 4 cases will be discussed:

- **Case 1:** A patient with clear cell ovarian cancer on the background of endometriosis underwent interval debulking surgery. A full-thickness rectal defect occurred due to rectal adhesions, which was recognized intraoperatively and repaired in two layers. Intraoperative colonoscopy confirmed no leakage.
- **Case 2:** A patient undergoing robotic hysterectomy for a benign indication sustained a full-thickness gastric injury with the Veress needle at Palmer's point during the first insufflation. The defect was repaired in two layers and endoscopy confirmed integrity.
- **Case 3:** In a patient with bladder endometriosis, a full-thickness bladder defect occurred during excision of the endometriotic lesion. It was repaired with two-layer suturing.
- **Case 4:** A patient with serous ovarian cancer undergoing interval debulking developed an inferior mesenteric artery (IMA) injury during paraaortic lymphadenectomy. Haemorrhage was controlled with a vascular clip, and the IMA was ligated.

Results

All complications were identified intraoperatively and successfully managed robotically without conversion to laparotomy. No postoperative complications, such as fistula formation, infection, or delayed bleeding, were observed. Postoperative recovery in all patients was uneventful, and hospital stays were within the expected range for robotic procedures.

Conclusions

Although robotic surgery offers significant advantages in gynaecologic oncology, intraoperative complications may still occur. Prompt recognition and effective robotic management of complications such as organ injury or vascular trauma can lead to favourable outcomes without the need for open conversion. Robotic surgery, when performed by experienced teams, remains a safe and effective approach even in complex oncologic cases.

<https://player.vimeo.com/video/1085851932?autoplay=1>

The Hidden Legacy of Incomplete Salpingectomy: A Case Report of Chronic Pelvic Pain and Intraoperative Challenges During Robotic Hysterectomy.

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Background

Salpingectomy is commonly performed for ectopic pregnancy or as a risk-reducing procedure. However, incomplete salpingectomy, especially when leaving a long tubal stump, may result in chronic complications¹, such as pain. This case highlights the anatomical and surgical implications of a retained left tubal stump about four years after salpingectomy.

Methods

A 40-year-old woman with a history of left salpingectomy for ectopic pregnancy presented with chronic pelvic pain and heavy menstrual bleeding. She elected for robotic-assisted total hysterectomy due to failed medical and conservative management. Intraoperatively, extensive adhesions were encountered, with the left tubal stump, omentum and sigmoid colon densely adherent to the left pelvic side wall and omentum. Notably, the stump was in close proximity to the left ureter, with surrounding inflammation and fibrosis, contributing to chronic pelvic pain. The anatomy was significantly distorted, necessitating increased surgery time for meticulous dissection to prevent ureteric injury and contributed to an overnight stay in the hospital for recovery. Histopathology confirmed chronic inflammation of the tubal remnant. No neoplastic changes were identified.

Results

This case underscores the long-term consequences of an incomplete salpingectomy. Retained tubal stumps can become a source of adhesions, chronic inflammation, and pelvic pain².

Their proximity to critical structures like the ureter may complicate future pelvic surgeries and elevate the risk of intraoperative injury. The omental adhesion further illustrates the peritoneal response to persistent inflammation.

Conclusions

Salpingectomy is typically performed by gynaecology registrars in training. It is important to emphasize the importance of complete salpingectomy. Leaving a long tubal stump (incomplete salpingectomy) may result in additional symptoms for patients, increased risk of intraoperative injury, longer operative times, and higher hospital stays and associated costs

A rare subtype of Obstructed Hemivagina and Ipsilateral Renal Anomaly (OHVIRA) syndrome: a case series of five patients

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Background

Obstructed Hemivagina and Ipsilateral Renal Anomaly (OHVIRA) syndrome is a congenital urogenital malformation disease with a wide spectrum of anatomical variants. Various Müllerian anomalies classification systems can elucidate the anatomical features of OHVIRA syndrome, such as the ESHRE/ESGE and new ASRM classification system. With the accumulating cases in our tertiary referral centre, a rare subtype of OHVIRA syndrome possessing complex anatomical variations was identified. The aim of this study was to summarize the clinical characteristics, imaging features and surgery options of this type of OHVIRA syndrome, therefore expanding the contents of existing classification system.

Methods

This is a single centre retrospective study, enrolling patients diagnosed with OHVIRA syndrome in our centre from January 2000 to December 2023, with intact charts and imaging results retrieved from hospital information system. The definite subtypes of OHVIRA cases were confirmed by surgery notes. Then, we analysed the anatomical features, clinical manifestations, complications, imaging modalities and features during diagnosis as well as the managements of these cases. Finally, a schematic diagram was proposed to properly illustrate this subtype.

Results

Among 168 cases enrolled, we identified 5 (3.0%) cases possessing similar anatomical variations which can be classified as this rare subtype of OHVIRA syndrome. This subtype was characterized by uterine didelphys, obstructed hemivagina, unilateral cervical atresia and communicating uteri with fistula between cervixes. The mean onset age of this subtype was 19.40 ± 8.70 and the mean age been diagnosed was 22.00 ± 7.84 , which was significantly older than that of complete obstructed subtypes ($P < 0.001$). In terms of clinical manifestation, all cases complained of dysmenorrhea or periodic pelvic pain, while only 1 case with the symptom of abnormal bleeding. 1 case developed secondary pelvic inflammation disease and 3 cases suffered from pelvic endometriosis (1 with ovarian and peritoneal endometriosis, 2 with peritoneal endometriosis only). Pelvic ultrasound and magnetic resonance imaging (MRI) were performed on all the cases. 2 cases were performed 3D reconstruction model to assist diagnosis and upcoming surgery. Among them, 3 cases successfully identified the fistula and cervical atresia by pelvic MRI before surgery. Among all the 5 cases, 2 patients suffered from repeated operation and all patients finally received ipsilateral hysterectomy to relieve obstruction.

Conclusions

As a rare female genital tract malformation disease, OHVIRA syndrome should be more detailed classified in order to proper diagnosis and treatment. Here we first identify and report this new subtype of OHVIRA syndrome and summarize its characteristics. Patients with this subtype generally get diagnosed at a later age and display symptoms and complications more like completely

obstructed subtypes. In addition to ultrasound, pre-operative evaluation of MRI should be performed to better illustrate the anatomical features if this subtype is doubted. Finally, unilateral hysterectomy is recommended to relieve obstruction in this subtype.

Analysis of risk factors associated with uterovaginal canalization in fertility-preserving management of congenital cervical malformation

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Background

This study aimed to determine the incidence, indications, and risk factors for reoperation and to assess fertility preservation outcomes in patients with congenital cervical malformation (CCM) undergoing laparoscopically assisted uterovaginal canalization.

Methods

In this retrospective case-control investigation conducted at a tertiary teaching hospital from January 2003 through April 2024, 82 CCM patients with complete clinical records were reviewed. Participants were divided into a reoperation group (n = 35) and a control group (n = 47) based on the need for secondary surgery. All patients were also stratified by fertility preservation outcome into a fertility-preserved cohort (n = 66) and a hysterectomy cohort (n = 16). Demographic and clinical characteristics, surgical techniques, time to reoperation, indications for reoperation, and postoperative results were extracted from medical records and supplemented by telephone follow-up.

Results

Successful primary uterovaginal canalization was achieved in 47 patients (57.3%), whereas 35 patients (42.7%) required reoperation at intervals ranging from 2 weeks to 12 years (mean 32.6 months). Indications for reoperation included postoperative infection with fever, pelvic mass formation, restenosis or canal obstruction, and persistent abdominal pain. Kaplan-Meier analysis demonstrated that intraoperative placement of a cervical stent significantly extended the reoperation-free interval ($P < 0.05$), while prolonged delays before initial treatment correlated with shorter reoperation-free survival ($P < 0.05$). Overall, 66 patients (80.5%) retained uterine function and fertility, whereas 16 underwent hysterectomy. Multivariate logistic regression identified cervical obstruction as a favourable predictor of successful fertility preservation ($P = 0.007$).

Conclusions

Approximately 40% of CCM patients required reoperation following uterovaginal canalization, yet 80% ultimately preserved fertility. Timely surgical intervention and intraoperative cervical stenting were associated with longer reoperation-free intervals. Patients with cervical obstruction demonstrated superior fertility-sparing success compared to those with other CCM subtypes.

Uterine fundus remodelling after hysteroscopic metroplasty for uterine septum: a prospective study.

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Background

The septate uterus is the most common congenital uterine malformation and is typically treated by hysteroscopic metroplasty. This study aims to evaluate uterine fundus remodelling after hysteroscopic metroplasty in patients with partial or complete uterine septum (classified as U2a or U2b according to ESHRE-ESGE classification), with particular attention to changes in uterine cavity morphology three months after the procedure using three-dimensional transvaginal ultrasound.

Methods

This single-centre, observational, prospective cohort study included patients, diagnosed with a uterine septum (U2a or U2b), who underwent hysteroscopic metroplasty between January 2018 and January 2024 at the Division of Gynaecology and Human Reproduction Physiopathology, IRCCS Azienda Ospedaliero-Universitaria di Bologna, Italy. All patients underwent standardized three-dimensional transvaginal ultrasound at baseline and at 3 months postoperatively, performed at our centre. The ultrasound evaluation focused on uterine fundal shape, categorized as concave, flat, or convex. After assessing the degree of morphological change following the procedure, patients were stratified according to the initial septum type (partial – U2a or complete – U2b) to compare remodelling patterns between groups. The significance of these structural changes was determined through statistical analysis.

Institutional Review Board (IRB) approval was obtained from the local ethics committee.

Results

A total of 107 patients were included - of which 11 with concave shape of uterus, 46 with flat uterus and 50 with convex uterus - and the findings demonstrated a statistically significant morphological transition of the uterine fundus from concave or flat to convex at 3 months postoperatively in patients with either a complete or partial septum following metroplasty ($p = 0.02$).

However, in a sub-analysis limited to patients with a complete uterine septum (59 women), the remodelling effect was statistically significant ($p = 0.046$), while in the subgroup of patients with a partial septum (48 women), significant changes were not observed due to the high prevalence of normal convex uterus at the baseline evaluation.

No major complications or intrauterine adhesions were observed.

Conclusions

Hysteroscopic metroplasty induces substantial uterine fundus remodelling, with a marked shift toward a physiologically convex shape, particularly in cases of complete septa (U2b). Three-dimensional transvaginal ultrasound proves to be a valuable tool for monitoring anatomical outcomes and informing postoperative management and fertility planning. However, data on obstetric outcomes in relation to the degree of morphological change following the procedure are currently lacking and warrant further investigation. Future prospective studies with larger sample sizes are needed to address these questions.

Laparoscopic Management of Bulky Para-Aortic Nodal Diseases in Primary Ovarian Cancer: A Ten Step Video Demonstration.

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Background

Ovarian cancer remains the leading cause of death among gynaecologic malignancies, largely due to late-stage diagnosis. Achieving zero residual tumour at surgery is crucial and has clearly been linked to improved survival outcomes, as demonstrated by several studies and subgroup analyses of large, randomized trials (EORTC 55971, CHORUS, SCORPION, JCOG0602). Minimally invasive surgery (MIS) has been proposed to achieve complete resection and improve perioperative outcomes. While MIS is increasingly accepted for staging early-stage ovarian cancer, selected interval debulking procedures, and recurrent cases, its application in primary advanced disease remains limited to anecdotal reports in the literature.

Methods

We present a case demonstrating the use of MIS in a patient diagnosed with primary ovarian cancer characterized by isolated bulky para-aortic nodal metastases. Detailed preoperative imaging and laparoscopic assessments excluded peritoneal carcinomatosis. Written informed consent was obtained from the patient for the procedure and scientific data analysis.

Results

The 48-year-old patient had favourable clinical factors, including normal BMI and no significant surgical history. A ten-step standardized laparoscopic technique was applied, successfully achieving complete resection of bulky para-aortic lymph nodes. Technical nuances included retroperitoneal access, precise identification of anatomical landmarks, meticulous dissection around major vascular structures, and careful nodal excision. The procedure confirmed the feasibility and safety of this minimally invasive approach in the described clinical scenario.

Conclusions

This case supports the feasibility and safety of MIS for the resection of isolated bulky para-aortic nodal metastases in carefully selected patients with primary ovarian cancer. By detailing technical nuances, we aim to contribute to the expanding body of knowledge in minimally invasive gynaecologic oncology.

<https://player.vimeo.com/video/1090154608?autoplay=1>

Para-aortic sentinel lymph node in ten steps.

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Background

The optimal approach to lymph node staging in locally advanced cervical cancer (LACC) is currently under investigation. The phase III PAROLA trial compares surgical lymphadenectomy versus PET-CT alone for nodal staging in FIGO IIIC1 patients. The primary objective is to evaluate disease-free survival based on the chosen staging strategy. While PET-CT is less invasive, it may underestimate nodal involvement. Surgical staging is more accurate but associated with increased morbidity. The SENTI-PAROLA ancillary study aims to assess the feasibility and safety of a new surgical technique: para-aortic sentinel lymph node (SLN) detection. This approach could offer accurate histologic staging without the morbidity of full para-aortic lymphadenectomy. This video demonstrates the extraperitoneal technique for SLN detection in this setting.

Methods

The patient was positioned in dorsal supine with legs slightly shifted to the right to optimize left retroperitoneal access. An exploratory laparoscopy was first performed to exclude intraperitoneal disease. A total of 2 cc of indocyanine green (ICG) was injected vaginally into the anterior and posterior fornices at 3 and 9 o'clock positions, taking care to avoid injection into the tumour. Retroperitoneal access was then developed via an extraperitoneal approach. Layer-by-layer dissection exposed key anatomical landmarks. Florescence imaging was used to identify lymphatic channels. Sentinel nodes were visualized and dissected at the left and right common iliac arteries and the inter-iliac region.

Results

Three fluorescent SLNs were successfully resected. The extraperitoneal approach enabled clear anatomical exposure and preservation of major structures. Nodes were sent for ultrastaging. No intraoperative complications occurred. Final pathology confirmed negative SLNs.

Conclusions

This video illustrates a reproducible extraperitoneal laparoscopic technique for para-aortic SLN dissection. It provides surgeons participating in the PAROLA trial with practical guidance to perform the SENTI-PAROLA ancillary study safely and effectively.

<https://player.vimeo.com/video/1090259724?autoplay=1>

Safety and Effectiveness of ReLARC® Inserter for Hysteroscopic Intrauterine Device Placement: A Prospective Study

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Background

This study aimed to evaluate the safety and effectiveness of the ReLARC® inserter used in conjunction with hysteroscopy for the placement of frameless intrauterine copper-bearing devices (GyneFix) in patients seeking contraception.

Methods

This prospective, single-centre, open-label study was conducted from July 2022 to June 2025 at the A.O.U. "Federico II" of Naples and enrolled women aged 16–48 years, with desire of contraception, undergoing hysteroscopic insertion of a ReLARC® device. The ReLARC inserter facilitates accurate placement of the GyneFix device under direct endoscopic visualization using a 19 or 15 fr Intrauterine Bigatti Shaver (IBS) hysteroscope. Data collected included procedural time, operator-assessed ease of insertion, pain scores (VAS), and transvaginal ultrasound measurements (fundus thickness [FT], knot penetration [KP], serosa-anchor distance [SA]). Follow-up visits were scheduled at 1 month and 1 year after insertion, during which pain, satisfaction, and device positioning were re-evaluated. Ease of insertion was graded by physicians on a 5-point scale.

Results

Out of 60 patients enrolled, 15 (25%) received a ReLARC-3 and 45 (75%) received a ReLARC-10 device. The mean age was 37.06 ± 8.19 years and mean BMI was 23.45 ± 3.45 . Mean time for device insertion was 3.19 ± 0.92 minutes. Patient-reported pain at insertion averaged 2.11 ± 1.00 (mild pain), and physicians rated the procedure as easy in most cases (mean difficulty score: 1.25 ± 0.83). Among the 21 patients who completed follow-ups at one year, FT, KP, and SA remained stable between insertion and follow-ups, with no statistically significant differences observed (FT $p=0.086$, KP $p=0.546$, SA $p=0.912$). Pelvic pain during follow-up was low and consistent ($p=0.655$). No expulsions or serious adverse events were reported.

Conclusions

The ReLARC® inserter enables safe and effective hysteroscopic placement of frameless copper IUDs, with high procedural success and tolerability. The procedure was brief, associated with low discomfort, and demonstrated consistent ultrasonographic positioning over time. These findings support ReLARC® as a reliable method for precise IUD placement, particularly advantageous in cases requiring direct visualization or in anatomically complex uteri.

Visualization of the Hypogastric Nerves Using Indocyanine Green during Deep Endometriosis Surgery

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Background

Endometriosis is a chronic inflammatory disease defined by the presence of endometrial glands and stroma outside the uterine cavity, affecting up to 10% of women of reproductive age [1]. Deep infiltrating endometriosis (DIE) can involve pelvic autonomic nerves, resulting in chronic pelvic pain and functional disturbances. Minimally invasive surgery (MIS) has increasingly incorporated near-infrared fluorescence (NIRF) imaging with indocyanine green (ICG) to enhance intraoperative anatomical identification and surgical precision [2].

ICG is a cyanine-based fluorescent dye that can be administered intravenously or locally, depending on the clinical application [3,4]. Once injected, it binds to plasma proteins and becomes visible under NIRF imaging, highlighting vascularized structures. The visualization of pelvic nerves is feasible due to their surrounding network of vasa nervorum, which fluoresce under ICG imaging [5].

Methods

We present a case of total laparoscopic management of DIE. During the procedure, 3 mL of ICG at a concentration of 0.25 mg/mL were administered intravenously. Using a fluorescence-capable laparoscopic platform, we achieved real-time visualization of the bilateral hypogastric nerves in the pararectal space, allowing for precise nerve-sparing dissection.

Results

This approach enabled complete excision of endometriotic lesions while preserving pelvic autonomic nerves, potentially reducing postoperative complications such as bladder, bowel, and sexual dysfunction. Furthermore, it may help minimize neuropathic pain by preventing inadvertent nerve injury.

Conclusions

The use of ICG-guided NIRF imaging offers a promising adjunct in complex gynaecologic surgeries, particularly in nerve-sparing approaches for DIE, where distorted anatomy poses a significant surgical challenge.

Disease-free survival outcomes of sentinel lymph node mapping in high-intermediate and high-risk endometrial cancer: a meta-analysis

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Background

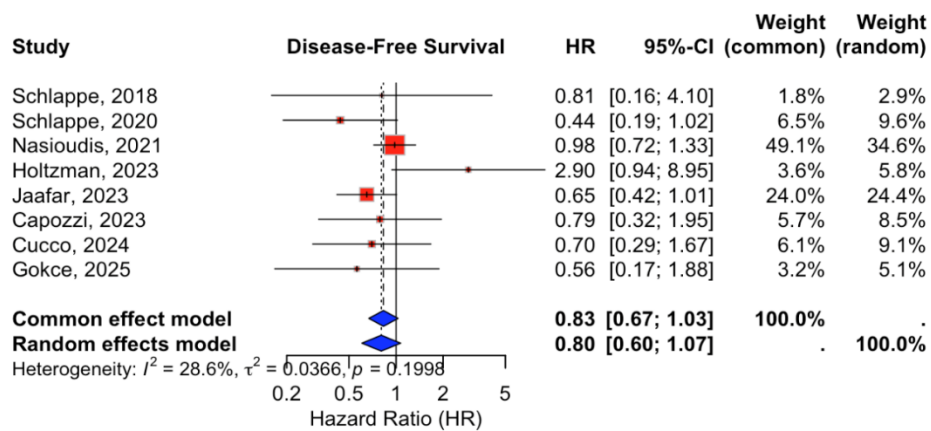
The primary objective of this meta-analysis was to evaluate the disease-free survival (DFS) associated with sentinel lymph node (SLN) mapping compared to systematic lymphadenectomy in patients diagnosed with high-intermediate and high-risk endometrial cancer (EC).

Methods

A systematic literature search was conducted across PubMed, EMBASE, and the Cochrane library for relevant studies published up to April 2025. Eligible studies included comparative observational studies that reported DFS for patients with high-intermediate or high-risk EC undergoing surgical staging with SLN mapping versus a systematic lymphadenectomy. Two reviewers independently performed data extraction and assessed the methodological quality of included studies. The main outcome measure, DFS, was pooled using hazard ratios (HR) with 95% confidence intervals (CI) employing a random-effects model. Heterogeneity was evaluated using the I^2 statistic.

Results

Eight studies were included in this meta-analysis, evaluating disease-free survival. The pooled analysis using a random-effects model demonstrated a hazard ratio (HR) for disease-free survival of 0.80 (95% CI: 0.60–1.07, $p = 0.135$) associated with sentinel lymph node mapping. This finding indicates no statistically significant difference in disease-free survival between SLN mapping and standard lymphadenectomy. Heterogeneity among the included studies was assessed as low to moderate ($I^2 = 28.6\%$; $p = 0.200$).



Conclusions

This meta-analysis suggests that sentinel lymph node mapping offers comparable disease-free survival to standard lymphatic assessment techniques in women with high-intermediate and high-risk endometrial cancer, potentially with a more favourable safety profile. SLN mapping appears to be a viable and oncologically safe alternative staging procedure in this specific patient population. Further prospective studies focusing on long-term outcomes and patient-reported quality of life would be beneficial to solidify these findings.

Effectiveness of linzagolix in a clinical setting: preliminary data of an italian real life experience.

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Background

Uterine fibroids are a common benign gynaecologic condition affecting up to 60% of women in their reproductive years. Heavy menstrual bleeding (HMB) significantly impairs quality of life and may require surgical intervention. Linzagolix, an oral GnRH antagonist, represents a promising non-surgical therapeutic option, especially for women ineligible for combination hormonal therapy due to cardiovascular risk factors. The objective is to prospectively evaluate the short- and long-term clinical effectiveness of Linzagolix, as well as the surgical outcomes after at least 3 months of therapy, within routine clinical practice.

Methods

This is a prospective observational study conducted at the University of Naples Federico II. Eligible participants are women aged >18 years with a diagnosis of symptomatic uterine fibroids and a PBAC score >100. Participants receive Linzagolix 200 mg once daily for at least 3 months. In non-surgical candidates, therapy may be tapered to 100 mg. PBAC scores, haemoglobin levels, patient-reported satisfaction, ultrasound and surgical outcomes are systematically recorded.

Results

As of December 2024, 20 women were enrolled, with a mean age of 39.2 ± 5.8 years and a mean BMI of 26.3 ± 3.9 kg/m². All participants presented with abnormal uterine bleeding (mean PBAC 226.8 ± 53.4) and anaemia (mean haemoglobin 10.5 ± 1.2 g/dL). After one month of treatment with Linzagolix 200 mg, 70% of the patients achieved a PBAC score below 100. The mean PBAC score decreased to 92.4 ± 44.1 ($p < 0.001$), and the mean haemoglobin level increased to 11.4 ± 1.0 g/dL ($p < 0.01$). No serious adverse events were reported during this treatment period.

Among the enrolled patients, 5 underwent hysteroscopic removal of fibroids. In all procedures, the cleavage plane was clearly visible, no patients required a second step myomectomy, and they were all dismissed without complications.

Conclusions

Data from this real-world cohort suggest that Linzagolix is effective in significantly reducing menstrual blood loss and improving haemoglobin levels within one month of treatment. Moreover, the use of Linzagolix plays a relevant role as a pre-surgical treatment, allowing optimization of the patients' preoperative profile, reducing uterine fibroid volume, and showing no intraoperative or postoperative complications.

Seeing the wood for the trees: robot assisted myomectomy in a patient with extensive bowel adhesions

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Background

Robotic-assisted laparoscopy in gynaecology has expanded in recent years as a result of the reported improved surgical performance without increasing operative time and the reduced intra- and post-operative complication rates, while reducing the need to convert to open abdominal surgery.

The aim of the surgical video is to illustrate the multiple benefits of robotic-assisted surgery that facilitate safe and effective execution of complex benign procedures through a minimally invasive approach.

Methods

We present a complex surgical case of a robot-assisted laparoscopic myomectomy in a 35-year-old nulliparous patient referred following an abandoned laparotomy (Pfannenstiel incision) due to significant small bowel adhesions. Patient was experiencing menorrhagia, dysmenorrhoea, dyspareunia, and subfertility. She had a background of tuberculosis (TB), treated in 2018.

An MRI of the pelvis showed a multi-fibroid uterus with a large fundal fibroid which was partially submucosal measuring 7 by 6cm. A 4cm fibroid was seen in the posterior myometrium and a 2cm fibroid in the anterior myometrium. Both ovaries appeared morphologically normal, with a left hydrosalpinx reported. Intra-operatively the reported left hydrosalpinx was in fact a peritoneal inclusion cyst secondary to the pelvic adhesions.

Results

The procedure was performed using the da Vinci Xi Surgical System (Intuitive Surgical, Sunnyvale, CA) using low intra-abdominal pressure (10mmHg). Meticulous adhesiolysis was carried out using a combination of monopolar diathermy and cold scissors. The wristed instrumentation and magnified 3D HD view enabled precise delineation of surgical planes, minimising the risk of organ injury (bowel or bladder), thereby reducing surgical morbidity and operative time.

Intrauterine ICG instillation was performed, employing FireFly fluorescence imaging to improve visualisation during myomectomy, minimising risk of breach of endometrial cavity and inadvertent suturing the endometrial cavity. The umbilical incision was extended to 2cm, and an Alexis port was inserted. The specimen was retrieved using an endo bag and cold knife morcellation was performed under direct vision. The patient made an excellent recovery and was discharged home on post-operative day 2.

Conclusions

The case highlights the multiple advantages of robotic surgery, including enhanced visualisation, improved range of instrument movement, and the ability to operate at lower intra-abdominal

pressures. As a result, a complex procedure that otherwise have required open surgery and involvement of colorectal surgeons, was successfully performed via a minimal access approach by a gynaecologist. Robotic-assisted laparoscopy is therefore a safe and effective strategy that can improve surgical outcomes by addressing challenges associated with both traditional laparoscopy and, to some extent, open surgery.

<https://player.vimeo.com/video/1095042450?autoplay=1>

BEST SELECTED ABSTRACTS VIDEO

ESGE34-0077 -

Best Selected Videos 1

Intraoperative ureter visualization using AI models versus near-infrared fluorescence

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Background

An intraoperative ureteral injury is a complication that can significantly affect the patient's quality of life; therefore, it must be carefully avoided. Intraoperative ureteral visualization by retrograde injection of indocyanine green (ICG) into the ureter is a secure and cost-effective method, described in many studies. In contrast, artificial intelligence (AI) has recently been applied to improve intraoperative visualization of the ureter. In this study, we compared these two techniques for laparoscopic hysterectomy.

Methods

We used the Survis-Hys (Jmees Inc., Chiba, Japan) AI support tool to identify ureters intraoperatively. During laparoscopic surgery, an auxiliary monitor was placed beside the main display, showing AI-based surgical images. For fluorescent ureter visualization, 2 mL of 2.5 mg/mL ICG was injected into each ureter through a cystoscopically placed ureteral catheter and observed using near-infrared fluorescence. During laparoscopic surgery, the ureter was identified using an overlay method.

Results

The AI technique could highlight the ureter after retroperitoneal access. However, caution is needed because of the possibility of misidentification when using such AI methods, primarily in magnified images and restricted surgical fields. The fluorescent method clearly outlined the ureter tract, even in regions not visible to the naked eye or in cases with limited visual fields due to bleeding or adipose tissue; therefore, enhancing safety during surgery. Although more procedures and preparation are required, this method can be effective in complex cases demanding ureteral identification.

Conclusions

AI is expected to contribute to safe surgical education and reduce complications, owing to its simple and non-invasive features. The fluorescence method is useful to visualize the ureter in complex cases and is expected to contribute to the expansion of minimally invasive surgical indications. Further development and validation of both methods are needed in future research.

<https://player.vimeo.com/video/1081755328?autoplay=1>

**ESGE34-0105 -
Best Selected Videos 1**

ICG-guided Laparoscopic Ovarian Transposition: safeguarding ovarian function prior to pelvic radiation.

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Background

The objective is to demonstrate the technique and efficacy of indocyanine green (ICG)-guided laparoscopic ovarian transposition as an ovarian function-preserving strategy prior to pelvic radiotherapy

Methods

A 34-year-old woman with locally advanced rectal cancer underwent laparoscopic ovarian transposition before neoadjuvant chemoradiotherapy. Ovaries were repositioned above the pelvic brim while preserving vascularization via the infundibulopelvic ligaments. ICG fluorescence was used intraoperatively to assess real-time ovarian perfusion

Results

ICG confirmed excellent perfusion post-transposition. The ovaries were repositioned in a higher abdominal location. No intraoperative complications occurred.

Conclusions

This video supports the use of fluorescence imaging as an effective ovarian function-preserving strategy in premenopausal women undergoing pelvic radiotherapy for rectal cancer. It underscores key technical aspects and highlights the need of a multidisciplinary approach in oncofertility preservation.

<https://player.vimeo.com/video/1083429539?autoplay=1>

Intraoperative transvaginal ultrasound to refine surgical strategy in rectosigmoid endometriosis

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Background

Bowel deep infiltrating endometriosis (DIE) is a severe form of endometriosis that is challenging to manage surgically due to complex lesion localization and infiltration. Preoperative imaging techniques, such as ultrasound and magnetic resonance imaging, can sometimes be misleading in evaluating bowel DIE because of significant anatomical distortion commonly found in these cases. Intraoperative ultrasound has been proposed as a solution to this issue, as it is performed after adhesion dissection, enabling a more accurate real-time assessment.

Methods

Step-by-step demonstration with narrated video content illustrating intraoperative transvaginal ultrasound to assess the extent of rectosigmoid deep infiltrating endometriosis. The study was conducted at a university hospital and included four women with suspected rectosigmoid deep infiltrating endometriosis undergoing laparoscopic surgery. Intraoperative transvaginal ultrasound was performed after pelvic dissection and rectal mobilization to assess the extent and depth of endometriosis and to guide the surgical approach—shaving, disc excision, or colorectal resection.

Results

Intraoperative transvaginal ultrasound was consistently feasible across several surgical settings for evaluating bowel deep infiltrating endometriosis involving the rectum and rectosigmoid junction. The technique provided reliable information regarding lesion localization, size, and infiltration depth, consistent with histopathological findings. It also complemented visual and tactile intraoperative assessment, aiding surgical decision-making.

Conclusions

Intraoperative transvaginal ultrasound may represent a valuable adjunct in the surgical management of rectosigmoid deep infiltrating endometriosis. Compared to preoperative imaging, it offers the advantage of being performed after pelvic organ mobilization, allowing for a more accurate assessment of lesion extent and depth. This technique may support selecting the most appropriate and least invasive bowel surgical approach, help reduce the risk of residual disease and contribute to the standardization of rectosigmoid endometriosis surgery.

<https://player.vimeo.com/video/1085359594?autoplay=1>

Surgical anatomy of the pelvis: a cadaveric demonstration of pelvic neuroanatomical structures

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Background

A comprehensive understanding of retroperitoneal anatomy is essential for enhancing surgical outcomes and minimizing complications. Cadaveric dissection provides a direct method for exploring neuroanatomical structures in detail, especially for the identification and isolation of pelvic nerve structures. Moreover, the effective management of gynaecological conditions—such as chronic pelvic pain and endometriosis—necessitates a clear understanding of the interplay between pelvic organ function and neuroanatomy. The aim was to identify and describe key neuroanatomical structures of the pelvis relevant to gynaecological surgical procedures and to provide a detailed anatomical framework to guide surgeons during such operations.

Methods

Deep pelvic dissections were conducted on nine female cadavers bilaterally. A systematic pelvic dissection begins by identifying the sigmoid colon, uterus, adnexa, and broad ligament. The dissection protocol followed a standardized sequence to identify major neurovascular landmarks and their interrelations with surrounding pelvic organs.

Results

After describing the sigmoid colon and uterus, peritoneal incision lateral to the infundibulopelvic ligament over the iliac vessels, the ureter and ovarian vessels were retracted medially to preserve the genitofemoral nerve. Dissection continues to the obturator fossa, revealing the external iliac vessels, obturator nerve, artery, and vein. The uterine artery crossing the ureter was clearly visualized.

The superior hypogastric plexus was identified near the aortic bifurcation, dividing into hypogastric nerves bilaterally. Further dissection exposes the lumbosacral trunk, sciatic nerve, and internal iliac branches, including the superior/inferior gluteal and pudendal arteries. The sacrospinous ligament is incised to access the pudendal neurovascular bundle.

Conclusions

In conclusion, a detailed understanding of deep pelvic neuroanatomy is crucial for performing gynaecological procedures, particularly those involving deep endometriosis and neuropelvic surgery. Cadaveric dissections serve as a valuable tool for demonstrating the anatomical relationships among the genitofemoral, hypogastric, obturator nerve, sciatic, pudendal nerves and lumbosacral trunk, thereby helping to prevent nerve injuries during gynaecological surgeries.

<https://player.vimeo.com/video/1085363094?autoplay=1>

Three of the worst organ injuries among 27,000 MIS (minimally invasive surgery) cases - how can we deal with nightmares like these?

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Background

In complex surgeries such as gynaecological cancer and severe endometriosis, there is a risk of damage to retroperitoneal vessels and the urinary tract, and intestinal tract. Of the past 27,000 minimally invasive surgeries, 23,800 laparoscopic and 3,200 robotic surgeries, the three worst cases of organ injury are shown, and the factors and measures to deal with them are presented.

Methods

Three cases will be presented.

- 1) During a robot-assisted extraperitoneal para-aortic lymph node dissection for uterine cancer, an avulsion injury of the inferior mesenteric artery occurred. Massive bleeding resulted. Suture haemostasis was performed in the same robotic surgery session.
- 2) During deep endometriosis resection, the ureter was misidentified as a deep lesion of the sacro-uterine ligament and 3 cm of the ureter was inadvertently resected. Laparoscopic reconstruction of the ureter with a Boari flap was performed.
- 3) During laparoscopic total hysterectomy for a patient with a large uterine myoma and rectal adhesions due to endometriosis, the rectum was completely lacerated and separated. After extensive resection of the injured area, reconstruction was performed using the double stapling technique.

All patients gave their consent for their surgical footage and data to be used for research and educational purposes.

Results

No cases required blood transfusions, or conversions to laparotomy and no complications occurred. The post operative course of all patients was benign.

Conclusions

By using appropriate repair methods, complications could be avoided, and the original minimally invasive approach could be maintained.

<https://player.vimeo.com/video/1085409571?autoplay=1>

Laparoscopic Abdominal Cerclage Using the Berci Needle

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Background

The aim of this report is to elucidate the application of the Berci needle in performing a laparoscopic abdominal cervical cerclage for a patient experiencing recurrent mid-trimester pregnancy losses attributed to cervical insufficiency. The aim is to evaluate the feasibility, safety, and clinical outcomes of this procedure in comparison to the conventional laparoscopic method.

Methods

A 30-year-old woman, gravida 3 para 0, presented with a history of recurrent second-trimester pregnancy losses due to cervical insufficiency. Although a transvaginal cervical cerclage was implanted early in her second pregnancy, the method appears to have failed, as the pregnancy ended in miscarriage at 18 weeks. After an extensive evaluation, she chose to undergo a laparoscopic abdominal cerclage by using a Berci needle. With little bladder dissection, a Mersilene tape was passed anterior to the cervico-isthmic junction using the Berci needle. The utilization of the needle facilitated a controlled and precise insertion of the tape, minimizing manipulation and operative time. The tape was tied anteriorly in a tension-free manner, and using Ethibond sutures, the two arms of the tape were fixed with one stitch for better integrity and less bladder irritation.

Results

The procedure was carried out in 40 minutes, with an estimated blood loss of 10 ml. No intraoperative or postoperative problems occurred. The patient experienced a smooth recovery and was discharged the next day. Two years later, the patient succeeded in spontaneous conception. Her pregnancy was closely monitored, and at 37 weeks, she had an elective caesarean section, which produced a healthy baby.

Conclusions

The laparoscopic abdominal cerclage involving the Berci needle was successfully executed, exhibiting an advantageous surgical profile characterized by little dissection, less blood loss, and a short operative time. In comparison to traditional laparoscopic methods, the Berci needle resulted in a more precise and effective cerclage placement, eliminating the necessity for significant bladder dissection or complex suture handling.

Consent was obtained from the patient for the use of anonymized video material for educational and presentation purposes.

<https://player.vimeo.com/video/1085410509?autoplay=1>

Minimally invasive hysterectomy for large uteri

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Background

Minimally invasive hysterectomy for large uteri presents significant technical challenges. We focus on the classification of large uteri using the Large Uterus Classification System (LUCS) and demonstrate advanced laparoscopic techniques to address the complexities associated with each type.

Methods

LUCS classifies large uteri into three types. Type 1 is characterized by the absence of vascular pedicle displacement. Type 2 involves cranial displacement of the adnexal vascular pedicles. Type 3 is defined by the displacement of uterine vessels, regardless of the adnexal pedicles.

Results

For Type 1 uteri, we perform ligation of the uterine arteries and parametrial vessels in addition to conventional TLH techniques to minimize intraoperative bleeding. In Type2 cases, we begin with dissection and transection of the parametrial tissue, followed preceding colpotomy. We then rotate the uterine axis to gain access to the displaced adnexal vessels. In some cases, transvaginal endoscopy provides improved visualization and access. Type3 presents the highest level of complexity, primarily due to the elevated risk of ureteral injury due to ureteral displacement. The umbilical ligament serves as a crucial anatomical landmark for identifying the uterine artery and ureter. Dissection of the ureter and bladder is essential, despite significant anatomical distortion. Additionally, in cases involving cervical fibroids, enucleation via laparoscopy or the vaginal route may be necessary to reduce uterine bulkiness. For all types, we perform fragmentation of the specimen efficiently using a long-handled scalpel followed by vaginal extraction.

Conclusions

The anatomical variations of large uteri require strategic approaches in laparoscopic surgery. Application of LUCS enables facilitates accurate assessment of surgical complexity, risk evaluation, and the selection of optimal operative techniques.

<https://player.vimeo.com/video/1085411537?autoplay=1>

Total Laparoscopic Hysterectomy For Non- Puerperal Uterine Inversion Secondary to prolapsed Submucosal fibroid

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Background

Non-puerperal uterine inversion (NPUI) is a rare gynaecological issue that presents with symptoms such as vaginal bleeding, pelvic pain, and a mass protruding from the vagina. Historical references to uterine inversion can be found in ancient Hindu Ayurvedic texts (2500–600 B.C.), while Hippocrates is credited with the first definitive medical account.

While the mechanisms behind obstetric uterine inversion are well-established, those related to NPUI are less understood. When the myometrium distends due to a tumour within the uterine cavity, it may become overstimulated and initiate contractions that can dilate the cervix and promote the expulsion of the tumour, potentially pulling its fundal attachment. The tumour's weight or heightened intra-abdominal pressure from activities like coughing, straining, or sneezing may also play roles in NPUI.

Methods

A 45-year-old multiparous woman with recurrent fibroids presented with a 6 cm vaginal mass, severe anaemia (Hb 58 g/L), and lower abdominal pain. Preoperative optimization included iron infusion (Hb improved to 120 g/L) and GnRH analogues (Prostap 3.75mg ×2) to reduce fibroid size.

Results

Imaging Findings

MRI: Complete uterine inversion with a 5.8 cm fundal fibroid on a vascular pedicle, cervical dilation (6 cm), and distorted uterine cavity.

Ultrasound: Uterine dimensions 75×65×45 mm, 35 mm submucosal fundal fibroid, and 1 mm endometrial thickness.

Surgical & Histopathological Results

Laparoscopy revealed uterine inversion involving the left fallopian tube, with normal adnexa. Histopathology confirmed the presence of a submucosal fibroid and adenomyoma.

Conclusions

NPUI's rarity and nonspecific symptoms necessitate high clinical suspicion, particularly in patients with fibroid history.

Correction of anaemia and reduced fibroid size are critical for surgical success.

Laparoscopic hysterectomy demands advanced skills to navigate distorted anatomy and preserve surrounding structures.

NPUI management necessitates multidisciplinary collaboration, meticulous imaging evaluation, and tailored surgical planning.

This case underscores the importance of recognising pedunculated fibroids as a primary aetiology and highlights laparoscopic hysterectomy as a definitive treatment in selected patients.

<https://player.vimeo.com/video/1085480129?autoplay=1>

**ESGE34-0335 -
Best Selected Videos 1**

Robotic V-Notes Hysterectomy

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Background

This case report aims to illustrate the feasibility and safety of robotic-assisted vaginal natural orifice transluminal endoscopic surgery (V-NOTES) hysterectomy in the management of a benign gynecologic condition.

Methods

A 42-year-old primiparous woman with symptomatic uterine fibroids and a history of failed medical management was selected for robotic-assisted V-NOTES hysterectomy. Preoperative imaging confirmed a 13 cm intramural fibroid. The procedure was performed under general anaesthesia using a robotic platform with transvaginal access. Pneumovagina and pneumoperitoneum was established, and a three-arm robotic system was docked. The uterus was successfully detached via robotic-assisted V-NOTES and extracted through the vaginal canal without the need for abdominal incisions.

Results

The total operative time was 110 minutes, and estimated blood loss was 100 ml. No intraoperative complications occurred. The patient resumed oral intake 3 hours postoperatively and was discharged on postoperative day 1. Pain was minimal, with a VAS score of 2 at 12 hours. At 2-week follow-up, the patient reported no complications and a rapid return to daily activities.

Conclusions

Robotic-assisted V-NOTES hysterectomy appears to be a feasible and safe approach for selected patients. It combines the advantages of robotic technology with the minimally invasive benefits of natural orifice surgery, potentially enhancing recovery and cosmetic outcomes. Larger studies are needed to confirm these preliminary results.

<https://player.vimeo.com/video/1085520221?autoplay=1>

Laparoscopic transperitoneal repair for a case with recurrent VVF (vesicovaginal fistula) with previously failed 5 fixing surgeries

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Background

V-V-F (vesicovaginal fistula) after hysterectomy is a nightmare for both patients and gynaecologic doctors. Small and fresh (without epithelization) VVF can be treated conservatively by bladder drainage only, with a 10% spontaneous healing rate. Fulguration may sometimes be helpful for those epithelized small holes. However, in most cases, these conservative methods will fail, and the performance of surgery is needed.

VVF can be repaired either vaginally or abdominally. The Latzko transvaginal repair is usually the first-line surgery preferred by gynaecologic doctors. The urologist may prefer abdominal approach (either trans-vesical or trans-peritoneal). However, both methods have a certain risk of recurrent fistula formation.

In this video, we will demonstrate a case with supratrigonal VVF after an open abdominal hysterectomy 8 years ago. In the subsequent 3 years, she received totally 5 surgeries to fix her problem (2 times transvaginal Latzko repair by gynaecological doctor, 1-time transvesical repair by urologist, 1-time robotic transperitoneal repair by urologist, and 1 time open transperitoneal approach by urologist). For all these 5 procedures, VVF recurred in post-operative 1 to 14 days. Finally, she was successfully treated with laparoscopic transperitoneal VVF repair (with omentum flap patching) by us.

Methods

Surgical video review, edited.

Results

Cystoscopy was performed first, identifying the fistula hole inside the bladder. A Sarot clamp was introduced from the vagina hole. An epidural cath was introduced cystoscopically and was grabbed outside the vagina through the fistula tract. Ureter stents were then inserted bilaterally. Then the laparoscopy was set up. After adhesiolysis, the peritoneum overlying the vagina cuff was opened, identifying the endopelvic fascia. Then the vesico-vaginal space was opened (with great difficulties from previous repeated surgeries-induced scarring). Paravesical spaces were also opened, in order to help identifying the exact surgical plane of endopelvic fascia, and for displacing the terminal ureter away from the upper and middle vagina. Finally, the vesicovaginal space was well developed, identifying the fistula tract with adequate margin. The epidural cath inside the fistula tract was then removed, and the vesical and vaginal wound were debrided and repaired separately. (bladder wall repaired in 2 layers, and vagina wound repaired in 1 layer). Then an omentum flap was interposed between bladder and vagina. The Foley catheter and double J stent were kept in place for 2 weeks. The patient recovered very well and was so happy to be dry again.

Conclusions

Recurrent or complex VVF can be successfully treated with a laparoscopic transperitoneal approach. The bladder wound and vaginal wound can be well repaired under excellent vision, and an omentum interposition flap can be applied to promote additional blood supply, which should decrease the recurrence rate of VVF.

<https://player.vimeo.com/video/1085737615?autoplay=1>

3D MRI Reconstruction as Part of Step-by-Step Pre-Surgical Planning Process for Anatomically Challenging Fibroid Localization

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Background

The goal of this presentation is to demonstrate the value of preoperative 3D MRI reconstruction in guiding a minimally invasive approach to resect a vaginal myoma in a complex anatomical setting.

Methods

We present a step-by-step visual narration of the pre-surgical planning and laparoscopic management of an anterior vaginal wall fibroid. Vaginal ultrasound suggested the diagnosis. A 3D MRI reconstruction was used to better define anatomical relationships and design the surgical plan in a patient presenting with pelvic pain, vaginal discharge, and difficulty voiding the bladder.

Results

The surgical steps were the following

1. Initial anatomical exploration
2. Opening peritoneal vesico-uterine fold
3. Opening Right and Left paravesical fossa (medial side).
4. Bladder identification and exposure.
5. Dissection between posterior bladder face and anterior myoma face. Anatomical identification.
6. Myoma exposition / traction. Accidental anterior vaginal wall opening.
7. Dissection plane between myoma and anterior vaginal wall. Exeresis of remanent anterior vaginal wall
8. Vaginal closure and hemostasia
9. Intrabag myoma extraction. Hemostasia, haemorrhagic vein identification.
10. Haemostatic suture. Final vision

The use of 3D MRI reconstruction facilitated clear anatomical understanding, guided a safe dissection, and supported the choice of a laparoscopic approach to protect the bladder trigone area.

Conclusions

This case highlights how 3D MRI reconstruction enhances anatomical understanding, particularly in complex or atypical scenarios. A laparoscopic approach was chosen instead of a vaginal or abdominal approach to allow for more accurate dissection of the posterior bladder wall and to avoid damaging

the bladder trigone area. Incorporating detailed imaging improves pre-surgical planning, enhances surgical safety, and increases confidence in decision-making when dealing with challenging gynaecologic procedures.

<https://player.vimeo.com/video/1085749440?autoplay=1>

The optimal surgical approach for deep infiltrating endometriosis of the parametrium involving the sacral root (type 1), or lumbosacral trunk and sciatic nerve (type 2)

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Background

Excision of deep infiltrating endometriosis involving the parametrium can be challenging and requires a good anatomical knowledge and surgical strategy. According to our experience there seems to be two different types of deep infiltrating endometriotic nodules in the parametrium, regarding the localization and the different pelvic structures that are involved. The aim of this video is to present a standardized and reproducible approach for the resection of medial nodules involving the sacral root (type 1) and lateral nodules involving the lumbosacral trunk and sciatic nerve (type 2).

Methods

In this educational video a step-by-step approach for the excision of type 1 and 2 nodules are shown, with special emphasis on the differences between both localizations.

Results

Type 1 nodules are located medially at the origin of the uterosacral ligaments. Surrounding structures include the ureter cranio-laterally, the rectum medially and the sacral roots dorso-laterally. These nodules require a medial approach on the pelvic sidewall. We first perform a ureterolysis, dissection of the rectum and rectovaginal septum if required. After identifying the hypogastric nerve, the internal iliac vessels may be dissected, and if necessary ligated. Caudally, the sacral roots and the inferior hypogastric plexus are then located and must be carefully preserved during the resection of the nodule.

Type 2 lesions are located on the lateral part of the pelvic sidewall. A different approach is used, starting from the lateral side of the external iliac vessels at the level of the bifurcation of the hypogastric artery and proceeding into the lumbosacral space. The next step is identifying the obturator nerve and vessels. The lumbosacral space is further dissected caudally, where the sciatic nerve lies at the bottom. At the anterior side of the nodule, we may encounter the bladder. The lesion is then progressively removed from the lumbosacral trunk and sacral roots. The pudendal nerve and posterior femoral cutaneous nerve are located on the medio-inferior side of S3 and have to be relieved from the endometriotic nodule if involved.

Conclusions

Deep infiltrating endometriosis of the parametrium involving the sacral root, or lumbosacral trunk and sciatic nerve are two distinct types, according to our experience. When following a systematic approach, the risk of inadvertent injuries of pelvic structures can be reduced.

<https://player.vimeo.com/video/1085759151?autoplay=1>

**ESGE34-0492 -
Best Selected Videos 2**

Robotic Secondary Cytoreductive Surgery: a personalized surgical approach for a triple-site Ovarian Cancer Recurrence

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Background

The role of secondary cytoreductive surgery (SCS) in recurrent ovarian cancer (ROC) has been increased in recent years. Randomized prospective trials have shown a survival advantage in case of complete gross resection. In this context, minimally invasive surgery (MIS) has taken on a significant role, especially in cases of single and oligometastatic recurrence. The aim of this video is to describe the feasibility of a robotic triple-site approach for SCS in ROC.

Methods

A case of oligometastatic platinum-sensitive ovarian cancer recurrence in a woman in her 40s is presented. Preoperative computed and emission tomography scans detected three sites of recurrence: a right cardio phrenic lymph node, a nodule at the hepatic hilum between the head of the pancreas and the hepatic artery, and interaortocaval lymphadenopathy below the left renal vein. After a preoperative 3D-reconstruction, a robotic SCS was performed in three anatomical regions.

Results

Complete cytoreduction was achieved. The operation time was 200 min and the estimated blood loss were 100 ml. The patient underwent extensive adhesiolysis because of previous surgery. No intraoperative complications occurred. The histological examination confirmed the metastatic involvement of the three lesions.

Conclusions

Robotic approach can be considered in selected patients with extra pelvic ovarian cancer recurrence, even in different anatomical sites, in oncological centres with a multidisciplinary team of expert surgeons. Patient selection and preoperative 3D reconstruction are crucial for the surgical planning.

<https://player.vimeo.com/video/1085774287?autoplay=1>

Robotic Lich-Gregoir Ureteroneocystostomy for Deep Infiltrating Endometriosis: precision in ureteral reconstruction.

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Background

Urinary tract endometriosis affects 1-5.5% of patients with endometriosis, with the bladder being the most common site of involvement. The ureter is affected in 9-23% of cases. Patients often present with symptoms like dysuria, hyperactive bladder, recurrent urinary tract infections, and hematuria. Surgical intervention is required in cases of ureteral compression, which may be intrinsic or extrinsic. Treatment options range from conservative ureterolysis to radical approaches like ureterectomy with end-to-end anastomosis or ureteroneocystostomy, the latter being indicated when the lesions are close to the vesico-ureteral junction. While laparoscopic approaches have been widely studied, data on robotic-assisted techniques are scarce. This video-article aims to demonstrate our technique and surgical setup for a complex case of ureteral deep infiltrating endometriosis (DIE).

Methods

This article provides a step-by-step explanation of the surgical technique, supported by narrated video footage.

Results

A 47-year-old female with symptomatic DIE involving the left parametrium and associated ipsilateral hydronephrosis was referred to our centre. Imaging and clinical evaluation confirmed significant ureteral obstruction due to extrinsic compression by a parametrial endometriotic nodule. Given the severity of the condition, surgical intervention was necessary to prevent renal damage and alleviate symptoms. The procedure was carried out robotically and involved the delicate excision of the left parametrial endometriotic nodule, followed by left ureteral reimplantation using the Lich-Gregoir technique to relieve ureteral compression and restore normal kidney function.

Conclusions

The surgery was performed using robot-assisted laparoscopic techniques to ensure minimal invasiveness, rapid recovery, and optimal outcomes. This video-article explains our technique and robotic setup for managing complex DIE cases involving both the parametrium and ureter. While the role of robotic laparoscopy in endometriosis treatment remains under investigation, its advantages—such as enhanced manual dexterity, three-dimensional vision, and improved ergonomics—make it an excellent choice for complex and time-consuming surgeries like ureteral reimplantation.

<https://player.vimeo.com/video/1085579761?autoplay=1>

Robotic Class C1 Radical Hysterectomy: A Comprehensive Anatomical Approach

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Background

Robotic Class C1 radical hysterectomy represents an advanced surgical technique designed to optimize oncologic radicality while preserving autonomic pelvic nerve integrity. This approach is particularly relevant in the management of early-stage cervical cancer, where functional outcomes such as urinary and sexual function must be preserved without compromising surgical radicality. The aim of this study is to present a standardized, stepwise robotic technique based on detailed anatomical principles and nerve-sparing dissection.

Methods

The surgical procedure is structured into seven key steps:

1. Sentinel lymph node (SLN) identification and removal.
2. Systematic pelvic lymphadenectomy (external iliac, obturator, internal iliac/presacral, and common iliac nodes).
3. Exposure of pelvic spaces and identification of critical neural structures for nerve-sparing.
4. Lateral parametrial dissection.
5. Ventral parametrial dissection.
6. Dorsal parametrial dissection.
7. Vaginal protective manoeuvres (vaginal manchette and endo-loop).

Robotic instrumentation allows for high-definition visualization and precise articulation during dissection, particularly in nerve-dense anatomical areas.

Results

This structured approach has shown excellent feasibility and reproducibility in clinical practice. The systematic exposure of anatomical landmarks facilitates accurate dissection while reducing intraoperative blood loss and the risk of ureteral and nerve injury. Functional outcomes, especially urinary continence and sexual function, are preserved in the majority of patients. The technique also allows for a comprehensive oncologic resection with negative margins and adequate lymph node yield.

Conclusions

Robotic Class C1 radical hysterectomy, when executed through a standardized, anatomical, and nerve-sparing strategy, offers an optimal balance between oncological effectiveness and functional preservation. The stepwise approach enhances reproducibility, reduces variability among surgeons, and supports training in advanced gynaecologic oncology procedures.

<https://player.vimeo.com/video/1091402658?autoplay=1>

Uterine artery ligation techniques in gynaecologic and pelvic surgery (Laparoscopic)

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Background

To demonstrate the safe surgical techniques during uterine artery ligation.

Methods

During the pararectal approach at the pelvic brim level, locating the external iliac artery medial to the psoas muscle and following it cranially to the pelvic brim reveals the ureter. Inferolateral to the ureter, the internal iliac artery is observed. After developing the superficial pararectal space and following the anterior part of the internal iliac artery, the uterine artery appears as the first medial branch arising from the internal iliac artery. During the paravesical approach, locating the umbilical ligament attached to the perivesical fatty tissue and dissecting it laterally to develop the superficial part of the medial paravesical space reveals the superior vesical artery at the dorsomedial aspect of the medial paravesical space. More cranially and inferior to the parauterine lymphatic tissue, the uterine artery can be seen as a medial branch arising from the distal portion of the internal iliac artery. During the pararectal approach at the broad ligament level, locating the ureter attached to the posterior leaf of the broad ligament reveals the internal iliac artery and superficial pararectal space. Dissection towards the anterior part identifies the uterine artery arising from the anteromedial section of the internal iliac artery.

Results

One or a combination of methods can be used according to the patient's characteristics.

Conclusions

Pararectal approach- pelvic brim level is the easiest way to find the ureter and internal iliac/uterine artery. Paravesical approach has a long way to find the uterine artery. It can be combined with other methods.

<https://player.vimeo.com/video/1085856726?autoplay=1>

Laparoscopic Pudendal Nerve Entrapment Surgery: Step by step description of two retroperitoneal approaches

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Background

Pudendal neuralgia is a neuropathic pain syndrome which arises in the sensory distribution of the pudendal nerve, mostly when the nerve is mechanically entrapped[1]. Sitting-triggered perineal pain and demonstrating pain relief after nerve blocks are characteristic features. Definitive treatment with surgery achieves relief in 60-80% of selected patients[2]. We sought to document the feasibility and early clinical impact of performing bilateral pudendal nerve decompression in a single session using two different anatomical approaches for a patient who met the validated Nantes diagnostic criteria[3] for pudendal nerve entrapment.

Methods

A 44-year-old woman admitted to our clinic for vulvar pain lasting for more than 10 years. She notes that her perineal pain worsens as soon as she sits, forcing her to abandon cycling she once enjoyed. The symptoms and findings revealed pudendal neuralgia according to the Nantes criteria. Bilateral laparoscopic pudendal nerve decompression was planned. A minimally invasive surgery was performed using a suprapubic laparoscopic approach with two 10 mm and two 5 mm trocars. The pelvis was explored in Trendelenburg position. Dissection on the left followed the internal iliac axis beneath the fallopian tube, whereas on the right, it proceeded lateral to the obliterated umbilical artery. Haemostasis and dissection were achieved with conventional bipolar energy.

Results

The operating time was 135 minutes, blood loss was 50 ml. The patient mobilized after six hours and discharged on day 2. Pain dropped to VAS 3–4/10 at two weeks and 2/10 at three months. She resumed office duties at week 4 and cycled by week 6. Continence and pelvic function remained intact; no wound, vascular, or neuropathic complications emerged in six months.

Conclusions

Resistant vulvodynia can be treated by advanced minimally invasive bilateral pudendal nerve release. Our experience shows that meticulous, side-specific dissection optimizes postoperative VAS improvement while preserving continence. Respecting anatomical planes and protecting vascular and neural integrity are the keys for a safe intervention for pudendal nerve entrapment in adults.

References:

1. *Chronic Pelvic Pain in Women: A Review*. JAMA, 2021. **325**(23): p. 2381-2391.
2. *Pudendal Nerve Entrapment Syndrome*, in *StatPearls*. 2025: Treasure Island (FL).
3. *Diagnostic criteria for pudendal neuralgia by pudendal nerve entrapment (Nantes criteria)*. Neurourol Urodyn, 2008. **27**(4): p. 306-10.

<https://player.vimeo.com/video/1088428905?autoplay=1>

Robotic approach on a rare localization of deep endometriosis involving the femoral nerve behind the psoas muscle

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Background

Deep endometriosis may involve somatic nerves, leading to pain, hyper- or hyposensitivity or muscular weakness. Excision of such deep nodules may be carried out using a robotic approach.

Methods

Didactic video demonstrating the approach on a deep endometriosis nodule locates paravertebrally, behind the psoas muscle, and infiltrating the femoral nerve. The placement of robotic trocars and the exposure of this hidden anatomic area is discussed in the movie.

Results

Da Vinci X robot with 4 arms was used to excise this deep nodule. the trocars were placed supraumbilically, two of them the medial axilar line, one on the medio-clavicular line, and one on the midline. Assistant trocar was placed homolaterally in the flank of the body. The lateral cutaneous nerve of the thigh, the femoral nerve and the obturator nerve were progressively released, with the anteversion of the psoas muscle using the robotic grasper. The operative time was 3h.

Conclusions

Deep endometriosis nodules may occur in unusual anatomical area, in which surgeons experience may be limited to a couple of cases. Robotic assistance may be most helpful, thanks to the 7 degree-mobility of arm which allow precise excision in very narrow spaces. Placement of trocars is essential in order to allow the best vision and to avoid conflicts between arms.

<https://player.vimeo.com/video/1089493497?autoplay=1>

Robotic Approach to Endometriosis with Fertility Preservation in an Adolescent Patient

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Background

This surgery involves an 17-year-old patient with a condition refractory to clinical treatment and a growing left endometrioma unresponsive to medical therapy. We observe extensive involvement of the peritoneum by endometriosis and begin by identifying the critical pelvic structures. We open the peritoneum and perform ureterolysis and neurolysis using the robotic platform. Note how the peritoneum becomes adherent and how crucial it is to identify the key anatomical structures beforehand to allow for safe excision of the disease. In this case, we used only three 8 mm robotic arms: one for the camera, one for the monopolar scissors for tissue dissection, and another for the robotic bipolar grasper, with assistance from a 5 mm laparoscopic assistant port. The same surgical systematization is applied on the right side, and the excision of the diseased peritoneum is greatly facilitated by the use of robotic monopolar energy and the EndoWrist instrument. We then proceed to the excision of the posterior peritoneum in the retrocervical region. Next, we perform a left oophoroplasty with barbed suture. Finally, the appendix, which was affected but not detected on imaging, is removed.

Methods

Surgery of one female adolescent patient with endometriosis

Results

Robotic surgery for endometriosis treatment. Surgery done in one time.

Conclusions

Use of technology associated with surgical systematization can improve teaching results and prevent future complications for endometriosis patients.

<https://player.vimeo.com/video/1090327982?autoplay=1>

Persistent Urogenital Sinus with Associated Complete Bicorporeal Uterus, Double Cervix and Partial Longitudinal Non-Obstructing Vaginal Septum

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Background

To describe a minimally invasive hysteroscopic approach for the diagnosis and treatment of persistent urogenital sinus (PUGS) associated with a complete bicorporeal uterus, double cervix and a partial longitudinal non-obstructive vaginal septum (U3bC2V1 according to ESHRE/ESGE 2013 classification system). PUGS is a rare congenital anomaly where the urethra and vagina converge into a single distal channel, opening through a common perineal orifice. It is frequently associated with renal, anorectal, or Müllerian malformations, and commonly occurs in the context of disordered sexual differentiation (DSD), such as congenital adrenal hyperplasia (CAH).

Methods

We report the case of a 39-year-old woman diagnosed with PUGS and U3bC2V1. A "one-stop" diagnostic approach, combining 2D/3D transvaginal ultrasound (TVUS) and office hysteroscopy prior to surgical treatment, was performed at the Digital Hysteroscopic Clinic of Fondazione Policlinico Universitario Gemelli IRCCS, Rome.

Results

Genital examination revealed clitoral hypertrophy and partial fusion of the labia minora, with the urethral meatus initially not visible. Vaginoscopy identified a 1 cm common channel (PUGS), branching anteriorly into the urethra and posteriorly into the vagina. A partial longitudinal non-obstructive vaginal septum and a double cervix were observed. 3D TVUS enabled the diagnosis of a complete bicorporeal uterus with multiple fibroids distorting both hemiuteri. The cavity of the left hemiuterus, accessed via the left cervix, appeared reduced in volume and compressed by intramural and subserosal fibroids. The cavity of the right hemiuterus presented a 10 mm G0 fibroid on the posterior wall. Bilateral endometrial biopsies were performed using a 5 mm hysteroscope. The vaginal septum was incised caudo-cranially with a 15 Fr bipolar mini-resectoscope using a Collins loop. Submucosal myomectomy was then performed using 15 Fr mini-resectoscope.

Conclusions

The integration of 2D/3D TVUS and hysteroscopy allows for early and accurate diagnosis of complex urogenital and Müllerian malformations, enabling the planning of the most appropriate personalized therapeutic strategy.

<https://player.vimeo.com/video/1090769788?autoplay=1>

Sentinel Lymph Node Sampling in Early-Stage Ovarian Cancer: A Minimally Invasive Approach to Staging

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Background

Epithelial ovarian cancer (EOC) remains a significant challenge in gynaecologic oncology, with early detection being crucial for favourable outcomes. Accurate surgical staging, particularly assessing lymph node involvement, is paramount for guiding adjuvant therapy and predicting prognosis. Traditionally, this has involved comprehensive pelvic and para-aortic lymphadenectomy, a procedure associated with substantial morbidity including lymphedema, nerve damage, and prolonged recovery. Given that only a subset of early-stage EOC patients harbours nodal metastases, the concept of sentinel lymph node (SLN) sampling, which identifies the first draining lymph nodes from a tumour, offers a promising strategy to reduce surgical invasiveness without compromising oncologic staging. This presentation aims to elucidate the current understanding of SLN sampling in early-stage ovarian cancer, exploring its feasibility, diagnostic accuracy, and potential to redefine surgical management.

Methods

• One millilitres of a 1.25 mg/mL indocyanine green (ICG) solution is injected to perivascular connective tissue of the infundibulo-pelvic ligament stump after salpingo-oophorectomy of adnexal mass side

Needle is inserted transcutaneously under laparoscopic guidance

5-15 minutes after the injection SLN searched

Results

The diagnostic accuracy of SLN sampling, particularly its sensitivity for detecting nodal metastases, has been reported to be high, often exceeding 90%, with low false-negative rates. This suggests that a negative SLN can reliably predict the absence of further nodal disease. Furthermore, SLN biopsy has been shown to detect low-volume metastatic disease (micrometastases and isolated tumour cells) that might be missed by conventional pathology on larger, non-sentinel node samples.

Conclusions

Sentinel lymph node sampling in early-stage ovarian cancer is a feasible and diagnostically accurate technique with the potential to significantly reduce the morbidity associated with traditional systematic lymphadenectomy. Its high detection rate and promising sensitivity for identifying nodal metastases suggest it could become a cornerstone of minimally invasive staging for this disease. While current evidence supports its utility, ongoing research is crucial to further standardize injection protocols, clarify the clinical significance of low-volume metastatic disease detected by ultrastaging, and validate long-term oncologic outcomes in larger prospective trials. The integration of SLN biopsy

into routine clinical practice holds the promise of optimizing surgical management, improving patient quality of life, and refining personalized treatment strategies for women with early ovarian cancer.

<https://player.vimeo.com/video/1091048102?autoplay=1>

BEST SELECTED PhD

**ESGE34-0026 -
Best Selected PhD**

The link between pollution, genomic instability and pelvic pain perception in the pathogenesis of endometriosis: a cross-sectional study.

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Aim

The aim was to evaluate the relationship between environmental pollutants, genomic instability and altered expression of ion channels into the peritoneum of patients affected by stage I-II endometriosis compared to healthy ones.

Background

Endometriosis affects 10-15% of reproductive-aged women. It has a deep impact on daily activities and employment. Its etiopathogenesis is not yet clear. Its occurrence may depend on a complex series of events.

Materials / Patients

This is a single-centre, cross-sectional study that was carried out at University Federico II of Naples. The study has been approved by the Local Ethics Committee (Protocol N° 06/22 of 12/07/2022). From July 2022 to April 2024, we collected data on 107 patients undergoing laparoscopic surgery for the eradication of both superficial peritoneal endometriosis and endometriomas (Group A= 45) compared to those undergoing laparoscopic surgery for benign adnexal disease (Group B= 62), coming from areas with low or high exposure to EDCs. We evaluated: pain perception through VAS score questionnaire in both groups; the severity of endometriosis-related symptoms and their impact on quality of life in Group A; CA 125 levels on blood exam in both groups; dioxins level on urine test in both groups; TRPV1 expression and MSI evaluation on tissue from peritoneal biopsies of women of both groups.

Methods / Results

The dioxin levels detected in the urine, while slightly higher in Group A, did not exceed the normal threshold values. CA125 blood dosage revealed a median concentration statistically significant in the Group A compared to the controls ($p < 0.05$). The MSI status evaluation showed a subset of patients with high microsatellite instability (MSI-H) in the endometriosis group that could be at a higher risk for the development of endometriosis-associated ovarian cancers. A lower expression of TRPV1 receptors in patients with stage I-II endometriosis compared to controls was reported.

Discussion

The project has some limitations: firstly, the number of cases slightly lower than controls; the quality of peritoneal tissue which has reduced the analysis of MSI and TRPV1; the observational nature of this cross sectional study. On the other hand, the project has the strength of having provided a broad overview on pain perception in patients with endometriosis as well as highlighted a reduction in the

expression of TRPV1 ion channels in the initial stages, which has never been reported in literature until now.

Conclusion

Our data highlights the complex interplay between environmental exposure, genomic instability and pelvic pain perception in such a widespread and still little-known disease as endometriosis.

Impact to Patients' Health

The lower expression of TRPV1 receptors in patients with stage I-II endometriosis, contrary to literature findings where higher expression is associated with more severe cases and CPP, offers new insights into the disease's biological mechanisms. This hypoexpression could suggest a different pathophysiological process in mild forms of endometriosis, potentially influenced by epigenetic and environmental factors, warranting further research into its role as a biomarker and therapeutic target.

<https://player.vimeo.com/video/1068294438?autoplay=1>

The effectiveness of cord blood and umbilical cord mesenchymal stem cell-derived exosome applications in the prophylaxis of intra-abdominal adhesions secondary to surgery

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Aim

It was aimed to use stem cell-derived exosome applications in an experimental animal model to prevent intra-abdominal adhesions secondary to surgery.

Background

Adhesions secondary to the surgery may cause numerous health care problems.

Materials / Patients

An experimental study.

Methods / Results

35 female Sprague Dawley rats were randomly divided into 7 groups.

Group 1: "Negative control group (no intervention)"

Group 2: "Positive control group (Experimental group)"

Group 3: "Received mesenchymal stem cells (MSCs) obtained from the umbilical cord"

Group 4: "Received exosomes obtained from MSCs derived from the umbilical cord"

Group 5: "Received MSCs obtained from adipose tissue"

Group 6: "Received exosomes obtained from adipose tissue"

Group 7: "Received exosomes (intravenously) obtained from umbilical cord MSCs"

The rats underwent a laparotomy, and peritoneal damage was created with the button method. Simultaneously prepared MSCs and MSC-derived exosomes were applied locally and intravenously to the groups. Three weeks later, re-laparotomy was performed, and postoperative adhesion formation was evaluated with the adhesion scoring system.

To evaluate microscopic adhesion, the levels of "inflammation," "fibroblastic activity," "collagen formation," and "vascular proliferation" were examined.

The treatment's effectiveness in wound healing, scar formation, and angiogenesis was evaluated by intergroup comparisons by immunohistochemistry staining with FGF, VEGF, HIF-1 α , and Collagen1 antibodies.

In the histological examination, adhesion thickness, fibrosis, inflammation and vascular proliferation were found to be the lowest in the negative control (group-1), then respectively, in groups 6 and 7 (similar), groups 4 and 5 (similar), group 3 and finally the highest in the positive control group (group 2). The differences in thickness between all groups were statistically significant ($p < 0.001$).

Similarly, the mean values of "Type 1 collagen antibodies", "Fibroblastic growth factor (FGF2)", "Vascular Endothelial Growth Factor (VEGF)" and "Hypoxia inducible Factor (HIF-1 α)" of the groups included in the study are listed from low to high as follows; in Group 1, then in Groups 6 and 7 (similar), in Groups 4 and 5 (similar), in Group 3 and finally in Group 2 ($p < 0.001$).

In histological examinations, an increase in the amount of extracellular matrix, PMNL infiltration, fibroblast activation, and high vascularity in the fibrotic focus are mostly seen in group 2, followed by group 3, group 4 and 5 (similar), and group 6 and 7 (similar), respectively ($p < 0.001$). Similarly, the same ranking is observed among the groups in Masson trichrome staining regarding collagen density, anti-collagen-1 staining level, anti-HIF-1 α , and anti-FGF-2 levels.

Discussion

Exosomes derived from umbilical cord MCH administered intravenously, and exosomes derived from adipose tissue MSC appear to be the most effective. Besides, application of exosomes can limit the stem-cell related complications.

Conclusion

Exosome treatments seem to be effective in preventing the development of adhesions after surgery.

Impact to Patients' Health

Our study will trigger the application of exosomes to prevent the intra-abdominal adhesions related to the surgery.

**Serum Calprotectin in Patients Diagnosed with Endometrial Polyps Evaluation of Levels,
Investigation of Its Value as a Noninvasive Diagnostic Method**

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Aim

In our study, it was aimed to evaluate whether the serum levels of calprotectin, which is known to be a strong pro-inflammatory marker, have a role in the pathogenesis of endometrial polyps and to reveal whether this information can be used in the diagnosis and prognosis.

Background

The histopathology of endometrial polyps is not fully known. There are studies showing that chronic infections localized to the endometrium also play a role in the development of endometrial polyps. Calprotectin, also known to be released from neutrophils and monocytes stimulated during the inflammatory process, has antimicrobial and apoptosis-inducing activity. It is also known to inhibit matrix metalloproteinases (MMPs), which are involved in various events such as angiogenesis, wound healing, embryonic development, inflammation, cancer and tissue destruction. There are many studies investigating its level in malignancies, showing that it is a new biomarker that can be used in early diagnosis.

Materials / Patients

A prospective cross-sectional case-control study was conducted, including 40 women diagnosed with endometrial polyps and 40 healthy volunteers as controls. Serum calprotectin levels were measured using ELISA. Demographic, clinical, and laboratory data were collected and analysed using SPSS 22.0.

Methods / Results

The forty patients diagnosed with endometrial polyp in a tertiary referral centre were compared with 40 healthy volunteers with similar demographic characteristics. In addition to serum calprotectin values, complete blood count, C-reactive protein (CRP), procalcitonin and ferritin parameters were also evaluated in both groups. The serum Calprotectin value was found to be significantly higher in patients with polyps larger than 1 cm compared to those with polyps smaller than 1 cm ($p < 0.001$). The threshold value for calprotectin in patients with polyp size >1 cm at the time of diagnosis was determined as 80.71 according to ROC analysis with 100% sensitivity and 75% specificity. The Calprotectin prognostic threshold value of 675.5 (ROC analysis) was evaluated as 100% sensitivity and 80% specificity in patients with polyp size >1.5 cm. Considering the infertility prognosis, the sensitivity of the calprotectin cut-off value of 443.8 (ROC analysis) was found to be 100% and the specificity was 62.9%.

Discussion

Calprotectin levels in benign polyps may be due to the pathways that prevent malignant transformation. Increased serum calprotectin levels in malign polyps because of showing malignant transformation maybe explained by neo-expression

Conclusion

The statistically significant increase in serum calprotectin level supports proinflammatory aetiology in the aetiology of endometrial polyps. It has been suggested that calprotectin neo expression is closely associated with biological malignancy of differentiated carcinoma, such as tumour differentiation and cellular atypism. It also suggests that it may be a valuable biomarker in predicting diagnosis and prognosis.

Impact on Patients' Health

It can facilitate patient follow-up and reduce the need for invasive procedures.

ABSTRACTS IN PLENARY SESSIONS

ESGE34-0015 -

Miscellaneous

Free communication: Robotic Single-Port versus Robotic Single-Site hysterectomy in early endometrial cancer: a case control study

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Background

Robotic single-port (SP) surgery represents the evolution of robotic single-site (SS) surgery and laparoscopic single-port surgery. All these approaches aim to minimize skin incisions to access the abdominal or pelvic cavities for surgical procedures. The aim of this study is to compare robotic single-port hysterectomy (RSPH) versus robotic single-site hysterectomy (RSSH) in early-stage endometrial cancer in terms of surgical outcomes.

Methods

This is a retrospective case-control study, comparing perioperative and postoperative outcomes of robotic single-port hysterectomy (RSPH, Cases) and robotic single-site hysterectomy (RSSH, Controls) in early-stage endometrial cancer patients. Descriptive statistics were performed on characteristics of patients. The Chi-square, Fisher exact and Mann–Whitney U-tests were used when comparing categories against categorical and continuous data, respectively.

Results

A total of 25 women who underwent RSPH between June 2024 and November 2024 were matched with 50 historic controls treated by RSSH in the same institution, by the same surgeon (E.V.), between December 2011 and September 2014. No significant differences were found in terms of age, BMI and histotype. Operative time was similar: 110 minutes in RSPH and 99 in RSSH ($p=0.76$). Blood loss was 50 ml in RSPH and 60 ml in RSSH ($p=0.14$). Hospital stay was shorter in RSSH (3.5 days in RSPH and 3 days in RSSH, $p=0.001$). No intraoperative complications occurred in both groups. Percentage of early postoperative complications was similar in both groups. No significant differences were detected in conversion rates and transfusions.

Conclusions

The new SP robotic system and the older SS robotic system differ significantly in design, capabilities, and surgical applications. The da Vinci SP features a single flexible camera and three multi-articulated robotic instruments, all passing through a single incision, allowing for improved instrument triangulation and articulation. In contrast, the Vinci Single-Site, uses straight, wrist-mounted instruments with limited articulation, which often leads to external instrument collisions and reduced dexterity. In fact, the SP offers greater freedom of movement and improved ergonomics, reducing

surgeon fatigue and improving surgical precision compared to the SS. Our study confirms safety and feasibility of RSPH for endometrial cancer without major differences from the RSSH in terms of surgical outcomes.

Free communication: Fertility-optimised surgical management of retained product of conception using TRS: a 12-year review

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Background

Retained products of conception (RPOC) occur in approximately 15–20% of first trimester miscarriages. Traditional surgical management using dilation and curettage (D&C) carries significant risks such as infection, intrauterine adhesions, and perforation due to its blind approach, which is particularly concerning for patients seeking to preserve fertility. Operative hysteroscopy, offering direct visualisation of the uterine cavity, presents a safer alternative. This retrospective study evaluates the reproductive outcomes of managing RPOC using a tissue removal system (Intra uterine BIGATTI shaver) in a private fertility centre in Iran.

Methods

A retrospective, single-centre study was conducted including 368 patients who underwent operative hysteroscopy with IBS® (Intra uterine BIGATTI shaver) for RPOC between December 2013 and March 2025. All surgeries were performed by the same operator. Patient history included 338 early miscarriages, 23 pregnancy terminations, 2 vaginal deliveries, and 5 caesarean sections. RPOC classifications were: 129 type 0, 204 type 1 or 2, and 35 type 3. Diagnoses were confirmed via transvaginal ultrasound and Doppler imaging.

Results

The median time to conception postoperatively was 47 days (range: 15 to 80). Mean operative time was 5 minutes, with an average fluid deficit of 200 ml. No intraoperative or postoperative complications occurred. Ultrasound follow-up confirmed complete uterine clearance in all cases. Pregnancy occurred in 342 patients: 254 through IVF (234 deliveries, 20 ongoing), and 88 through natural conception (77 deliveries, 11 ongoing). 26 patients had not conceived after six months. One patient with type 3 RPOC developed Asherman syndrome and did not conceive post-adhesiolysis. Uterine anomalies were identified in 24 cases and treated during the same session. Polyps were removed in 18 patients concurrently with RPOC.

Conclusions

Tissue removal system offer a safe, accurate, and fertility-preserving solution for managing RPOC. The method ensures complete evacuation under direct visual control, reduces the risk of complications associated with blind curettage, and supports improved reproductive outcomes. It is a valuable option for patients seeking conception.

Correlating laparoscopic classical and non-classical pelvic peritoneal endometriosis lesions with histological findings.

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Background

Traditionally, diagnosis of pelvic peritoneal endometriosis has been primarily based on laparoscopic visualization of "Classical" lesions. However, there is a growing recognition of "Non-Classical" endometriosis lesions seen at laparoscopy. Therefore, histological examination has recently been recommended to confirm the laparoscopic diagnosis. The prevalence of endometriosis in inflammatory and fibrotic peritoneum detected at laparoscopy remains to be investigated.

Methods

Study question:

What is the diagnostic accuracy of laparoscopy in identifying and categorising various types of pelvic peritoneal endometriosis and how does it correlate with histology?

Study design, size, duration:

This was a cross-sectional observational study which included 63 women of reproductive age presenting with chronic pelvic pain (CPP) who have undergone laparoscopic excision of peritoneal endometriosis in a single BSGE-accredited Endometriosis Centre over a 6-month period. A total of 158 peritoneal biopsies were obtained from different compartments of the pelvis. Laparoscopic appearances of the biopsies were correlated with their histological examination.

Participants/materials, setting, methods:

Eligible laparoscopic procedures were identified from the operative database between June 2022 to December 2022. The laparoscopic findings and histological reports were reviewed. Based on the laparoscopic appearance, the biopsies were classified into two main categories including 1) Classic endometriosis and 2) Non-classical endometriosis lesions, which were further subdivided into 3 types including a) Fibrosis, b) Inflammation and c) Not specified. Biopsy from normal appearing peritoneum was also included in the study.

Results

A total of 158 biopsies were included in the study. At laparoscopy, classical peritoneal endometriotic lesions were identified in 41 (26%), non-classical peritoneal lesions in 89 (56%), and normal peritoneum in 28 (18%). Non-classical lesions included fibrotic lesions in 52 biopsies (33%), inflammatory lesions in 15 (9.5%) and not specified in 22 (14%). Overall, histological confirmation of endometriosis was reported in 56% (89/158) of all biopsies. Endometriosis was confirmed by histology in 100% of biopsies with classical lesions (41/41) and 47% (42/89) of all non-classical

lesions. A total of 58% (30/52) of fibrotic lesions, 27% (4/15) of inflammatory lesions and 36% (8/22) of not specified biopsies showed histological evidence of endometriosis. A total of 21% (6/28) of biopsies from apparently normal peritoneum at laparoscopy showed endometriosis on histology.

Conclusions

The absence of classic endometriosis at laparoscopy does not exclude endometriosis. All "Classical" endometriosis lesions, half of the "Non-Classical" lesions and one-fifth of normal appearing peritoneum could have endometriosis. Histological examination of "Non-Classical" lesions and apparent normal peritoneum is therefore necessary to diagnose endometriosis.

Free communication: Indocyanine Green Fluorescence in Benign Gynecologic Laparoscopy: A Case Series Highlighting Intraoperative Safety and Surgical Precision

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Background

Although indocyanine green (ICG) fluorescence imaging is well established in oncologic gynecology, its application in benign minimally invasive procedures remains limited. ICG-enhanced visualization may facilitate clearer identification of the ureters, more accurate assessment of tissue perfusion, and improved intraoperative decision-making-factors that can help minimize complications in complex benign surgeries. This case series aims to evaluate the utility of intraoperative ICG fluorescence imaging in enhancing surgical precision and ensuring patient safety during benign gynecologic laparoscopic procedures.

Methods

We conducted a prospective case series involving 17 patients who underwent laparoscopic surgery for benign gynecologic conditions between January and December 2024, including deep infiltrating endometriosis (DIE) (n=13), isthmocele repair (n=2), complex myomectomy (n=1), and tubal permeability assessment (n=1). ICG was administered intravenously in doses of 2.5–5 mg, with repeat injections as needed (maximum dose: 2 mg/kg). In select cases, a diluted ICG solution (≤ 5 mg total) was instilled intrauterinely via a chromopertubation line on the uterine manipulator or intravesically via cystoscopy (≤ 25 mg in 50–100 mL saline), both using low-pressure techniques to minimize retrograde flow. Near-infrared fluorescence imaging was employed to visualize ICG distribution intraoperatively.

Results

ICG fluorescence imaging was successfully performed in all cases. In 12 patients (70,6%), ICG directly influenced intraoperative decision-making:

- In 8 cases of DIE: ICG enhanced visualization of ureters in fibrotic tissue, confirmed bladder wall integrity following complex adhesiolysis at the vesicouterine space, improved visualization of endometriotic lesions, and confirmed anastomotic perfusion after single-stapler rectosigmoid resection.
- In 2 isthmocele repair cases: ICG-guided perfusion assessment facilitated excision of fibrotic tissue and confirmed adequate vascularization of the reconstructed myometrium.

- In 1 myomectomy case: intrauterine ICG confirmed the integrity of the endometrial cavity following fibroid removal.
- In 1 tubal assessment case: intrauterine ICG enable real-time evaluation of tubal patency in a patient with suspected tubal factor infertility.

No intraoperative complications occurred, and postoperative recovery was uneventful in all cases.

Conclusions

Near-infrared fluorescence imaging with ICG is a safe and valuable tool in benign gynecologic laparoscopy, enhancing anatomical visualization and surgical precision across a variety of complex procedures.

Free communication: Long-term Outcomes following Robot Assisted Burch Urethropexy

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Background

The primary objective of this study is to characterize the long-term success and failure rates of robot-assisted Burch Urethropexy. Secondary objectives were to further characterize reoperation rates for following an unsuccessful robotic Burch procedure.

Methods

A retrospective cohort study was performed using postoperative outcome files for patients undergoing Robot-Assisted Burch Urethropexy procedures from 2014-2022 at a single academic center. Identified patients elected to participate in a series of patient questionnaires: Urogenital Distress Inventory (UDI-6), Decision Regret Survey (DRS), Satisfaction with Decision Survey (SWD), Patient Global Impression Severity Scale (PGI-S), and Patient Global Impression of Improvement Scale (PGI-I), in order to determine their long-term subjective outcomes. Retrospective chart review was performed to determine postoperative courses.

Results

Between 2014 and 2022, a total of 125 Burch Urethropexies were identified. Of these patients, a total of 66 patients successfully completed the postoperative patient questionnaires. Mean outcomes for each of the scored surveys are as follows: UDI-6 31.57, DRS 72.19, SWD 75.104, PGI-S 2.25, and PGI-I 2.96. Postoperative courses were reviewed and notable for sixteen patients undergoing repeat surgery within ten years following their Burch Urethropexies (12.8%). Of the sixteen reoperations, eleven procedures were performed for treatment of recurrent stress urinary incontinence, while the remainder of reoperations were performed secondary to other concomitant procedures performed for management of pelvic organ prolapse or abnormal uterine bleeding. Of the reoperations for management of stress urinary incontinence, four midurethral slings and seven periurethral bulkings were performed. Of the eleven reoperations performed, one patient needed have a periurethral bulking following placement of a midurethral sling, resulting in two reoperations.

Conclusions

Of those surveyed, patients reported an overall improvement in their stress urinary incontinence symptoms and quality of life. Patients were typically satisfied with their decision to undergo Robot Assisted Burch Urethropexy and had low incidences of decision regret. Of the 125 Burch Urethropexies performed, there was a reoperation rate of 8.8% for management of recurrent stress incontinence.

Free communication: Fertility, pregnancy course and perinatal outcomes after surgical excision of lateral parametrial endometriosis.

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Background

Lateral parametrial endometriosis (LPE) has a prevalence of approximately 17% in patients with deep infiltrating endometriosis (DIE) admitted to surgery. LPE has been associated with more severe disease, ureteral involvement and voiding dysfunction. LPE excision can lead to neurogenic postoperative pelvic organ dysfunctions and may require unilateral resection of the uterine artery. Given the potential impact of such surgery on the pelvic organs, the aim of our study was to describe the post-surgical fertility, pregnancy course and perinatal outcomes of patients who underwent LPE excision.

Methods

In this single-center observational retrospective cohort study, we included all consecutive women submitted to surgery for LPE between 2007 and 2023 in a tertiary level referral center for endometriosis.

Results

Of the 302 patients included, 90 (29.8%) actively sought pregnancy after surgery. Within this group, 48 (53.3%) achieved at least one intrauterine pregnancy and 46 (51.1%) achieved at least one pregnancy with live birth (LB), with an average gestational age at birth of 39 weeks and an average weight at birth of 3104g. Comparing patients with a post-surgical pregnancy with LB (LB; n=46) and patients seeking pregnancy but without LB (NLB; n=44) with regards to surgical procedures and anamnestic features potentially affecting fertility, significant differences were found only for age (LB= 32 y.o. vs. NLB= 35 y.o.; $p<0.05$), bilateral salpingectomy (LB= 2.2% vs. NLB= 15.9%; $p<0.05$) and history of infertility before surgery (LB= 37.0% vs. NLB= 79.5%, $p<0.05$). A double comparative analysis was then performed within the group of patients seeking pregnancy after surgery, based on the type of surgery: firstly, patients who underwent unilateral (ULP; n=76) and bilateral (BLP; n=14) LPE excision; secondarily, patients who underwent unilateral uterine artery resection (UAR; n=7) and not (NUAR; n=87). In both subanalysis, there were no significant differences regarding anamnestic features potentially affecting fertility and LB rates were comparable (ULP= 47.4% vs. BLP=71.4%, $p=0.17$; UAR= 57.1% vs. NUAR= 50.6%; $p=0.74$). Moreover, in the ULP vs. BLP comparison, there were no significant differences for the pregnancy course and neonatal outcomes. This last analysis was not feasible for UAR vs. NUAR comparison due to disproportion between the two groups, however a

total of 4 pregnancies among UAR group were reported, with an average gestational age at birth of 38 weeks and an average weight at birth of 2765g.

Conclusions

This study suggests that live birth rate after LPE excision is comparable to that of other DIE localizations. The bilateral LPE excision compared to the unilateral one and the resection of the uterine artery do not seem to worsen the considered outcomes. These data may serve as the basis for an appropriate counselling to women previously operated for LPE.

Free communication: Peritoneal Endometriosis—Reframing the Paradigm: Retrospective Validation of ABC™ and ABC™/AI as a Novel Enhancement in Surgical Detection and Excision

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Background

Peritoneal endometriosis remains one of the most challenging and underappreciated aspects of endometriosis care. It presents unique difficulties in understanding its etiopathogenesis, progression, and optimal treatment strategies. Despite being the most prevalent form of the disease, peritoneal endometriosis is frequently overlooked or dismissed in clinical practice—largely due to its subtle, non-pigmented appearance, the lack of reliable imaging tools or biomarkers, and the persistent misconception that it represents a minor or superficial disease subtype.

As a result, there has been a striking lack of high-impact scientific literature specifically addressing peritoneal endometriosis over the past two decades. Only recently has the field begun to shift its focus back to this area. New comparative studies are beginning to evaluate treatment strategies specifically for peritoneal disease. Importantly, the detection and localization of peritoneal endometriosis within the pelvis—long limited by conventional imaging—has only just begun to benefit from the application of AI-based visual recognition technologies.

Methods

We conducted a retrospective analysis of 539 peritoneal endometriosis surgeries, yielding 8,348 histologically confirmed lesions. Patients were grouped into:

- First-time surgery (n=307)
- Reoperation after prior Aqua Blue Contrast (ABC™) use (n=44) (Previously had a surgery with ABC™)
- Reoperation without prior ABC™ (n=188) (Previous surgery without ABC™)

Histopathological findings were compared across groups. Additionally, we developed and trained an AI model on annotated intraoperative images, comparing lesion detection performance under standard laparoscopy light versus ABC™-enhanced imaging. The ABC™ technique was used both to optimize intraoperative visualization and to augment AI training data.

Results

The average number of "endometriosis" lesions excised per patient was significantly lower in the reoperative ABC™ group (4.5) compared to reoperations without ABC™ (7.6) and first-time surgeries (8.0) ($p < 0.001$), suggesting more complete initial excision when ABC™ was used. Fibrosis scores were

also lower in the ABC™ group (mean 1.8) than in reoperations without ABC™ (2.27), showing a trend toward significance ($p=0.06$).

Moreover, AI-assisted detection sensitivity under standard white light was 30%. When ABC™ enhancement was applied, sensitivity increased to 80%, demonstrating the value of contrast-guided imaging in improving both real-time and AI-supported recognition of lesions.

Conclusions

Peritoneal endometriosis continues to be underdiagnosed and inadequately treated due to challenges in intraoperative visualization and clinical bias. Our retrospective findings support the use of ABC™ to improve completeness of excision and reduce disease recurrence. Furthermore, the integration of AI with contrast-enhanced imaging represents a novel and powerful extension of this technique, significantly improving detection accuracy and offering a scalable path toward surgical standardization. Together, these tools can transform peritoneal endometriosis care by enabling earlier recognition, more effective treatment, and improved outcomes in pain and fertility.

Free communication: Proof-of-Concept Study on Deep Learning-Based Segmentation of Autonomic Nerves in Nerve-Sparing Robotic Sacrocolpopexy

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Background

Preservation of autonomic nerves is essential during nerve-sparing sacrocolpopexy to maintain pelvic organ function. However, these nerves, particularly the hypogastric nerve and superior hypogastric plexus, are often difficult to distinguish intraoperatively due to anatomical variability and surgical complexity. This pilot study aimed to develop a deep learning model for the semantic segmentation of autonomic nerves using retrospectively collected surgical videos from robotic procedures of nerve sparing sacrocolpopexy.

Methods

A total of 100 frames from 20 videos of nerve-sparing robotic sacrocolpopexy were retrospectively collected and the phase involving presacral dissection was analyzed to collect the frames where the autonomic nerves branches were visible. Frames were manually annotated under expert supervision to identify the hypogastric nerve and superior hypogastric plexus branches. A deep learning model was trained to perform semantic segmentation of these structures. The model architecture used was previously validated on colorectal surgery by the group of M. Ito at the Department of Surgery, University of Tsukuba, Japan. In this study, we aim to validate and adapt this model on our dataset of robotic sacrocolpopexy procedures. Model performance was assessed via five-fold cross-validation using the Dice coefficient, a commonly used metric in the field of medical image analysis and computer vision that measures the similarity between two sets of data.

Results

Qualitative analysis showed that the model achieved a mean Dice coefficient of 0.40 across the annotated frames, corresponding to correct automatic identification of the structure in 40% of frames. Despite the limited dataset size, the model demonstrated preliminary feasibility for identifying autonomic nerves relevant to nerve-sparing pelvic reconstructive surgery.

Conclusions

This work represents a pilot proof-of-concept for the application of deep learning to autonomic nerve segmentation in robotic sacrocolpopexy using retrospective surgical video data. Efforts are currently underway to prospectively expand the video database and further validate the model in

this specific surgical context, with the goal of supporting intraoperative nerve identification and surgical decision-making in the future.

Free communication: Robotic and laparoscopic colo-rectal resection: 400 cases in one center

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Background

Deep infiltrative endometriosis (DIE) is the most severe form of endometriosis, which occurs in 7-10% of women of reproductive age and in 50% of women with the reduced fertility. The symptoms include dysmenorrhea, dyspareunia, dyschesia and dysuria, as well as asymptomatic hydronephrosis or the other organ dysfunction. The surgical excision of the endometrioid lesion is the main method if there are symptoms that cannot be corrected by medication.

Methods

this article analyzes 2,999 cases of surgical treatment of endometriosis from 2016 to 2024 in the Moscow Regional Research Institute of Obstetrics and Gynecology, Moscow, Russia. The surgical treatment itself, the perioperative period and complications were evaluated.

Results

2,999 surgical procedures for endometriosis were performed, of which 397 (13.2%) cases of colorectal endometriosis were surgically treated: in 20 (5.03%) cases, discoid resection was performed, in 178 (44.8%) cases, colon reshaping, in 199 (50.1%) cases, segmental resection, including the NOSE technique in 94 (23.6%) cases. The number of simultaneous operations was in 237 (14.7%) cases. The main complaints of patients with colorectal endometriosis were dysmenorrhea, dyspareunia, and dyschesia. Changes in stool frequency and consistency were the main complaints in patients who underwent segmental bowel resection. An assessment of complaints during 6-12 months after surgical treatment showed a significant decrease this parameter to the population average. Functional disorders after the surgery, such as incomplete emptying of the bladder, difficult urinating, rapid stools, constipation and dyschesia were the highest in the first 2 weeks of the postoperative period and lasted up to 2 months, the complete relief of functional disorders occurred 12 months after the surgery. Intraoperative complications occurred in 14 (5.9%) cases with laparoscopic access and in 8 (3.3%) cases with robot-assisted access. A recurrence of colorectal endometriosis, which required the repeated surgical intervention, occurred in 2 patients (8%). The study was conducted on the effectiveness of the anti-adhesive barrier, including 60 patients who underwent the colorectal resection for DIE. Of these, 50% (30) were intraoperatively injected with antiadhesion 10g (15) and mesogel 50ml (15), the control group consisted of patients (30) who did not receive an anti-adhesion barrier. In the postoperative period, thermometry was evaluated and laboratory monitoring was performed on days 1, 2, 3, and 14 in the postoperative period, including C-reactive protein, ultrasound monitoring of the pelvic organs condition. There was no significant difference in the performance between the groups.

Conclusions

Our results emphasize that performing surgical interventions on the colon is associated with a number of possible perioperative complications and postoperative functional disorders, which are leveled out after 6-12 months. Using of anti-adhesion barriers in patients who have undergone surgical treatment of infiltrative endometriosis does not affect the frequency of complications and functional disorders in the postoperative period.

Evaluating chronic endometritis in infertile women by hysteroscopy and immunohistochemistry

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Background

Chronic endometritis is an insufficiently investigated pathological situation in infertile women, associated with implantation failure and pregnancy loss. Hysteroscopy and endometrial biopsy have favorable predictive and diagnostic values in infertile women. However, limited studies have evaluated its effectiveness, and the exact benefits of this method are not completely investigated. The aim of this study was to evaluate the prevalence of chronic endometritis in infertile women by hysteroscopy and immunohistochemistry and to evaluate the fertility outcomes after endometritis therapy.

Methods

In total, 200 infertile patients with a mean age of 38 years underwent hysteroscopy on the 12th until 20th day of their menstruation cycle. Patients with tubal infertility factor were excluded from the study. Age, hormonal, status, Anti-mullerian Hormone, Body Mass Index, secondary diseases of the women, sperm quality and quantity of the man, infertility types: primary or secondary were recorded. At the hysteroscopy, biopsy was taken and assessed using immunohistochemistry by specific monoclonal antibodies against the CD56 marker for natural killer cells, CD138 for plasma cells, CD3 for T-lymph cells, CD20 for B-lymph cells. The prevalence of chronic endometritis (CE) in this group of 200 infertile women was evaluated through hysteroscopy and immunochemistry to be 75/200 (37,5%). After completing the antibiotic therapy for endometritis and controlling with new pipelle immunohistochemical endometrial biopsy the therapy of endometritis, the patients were followed up for at least 2 years for their fertility outcomes. Spontaneous pregnancies were reported after one year of follow up and then intrauterine insemination (IUI) and or in vitro fertilization therapy (IVF) was initiated in the rest patients and fertility results were documented. Primary end point of the study was pregnancy rates and secondary outcomes were life birth rates and miscarriages.

Results

The prevalence of CE was 42% (84/200) and 37,5% (75/200) based on hysteroscopy and immunohistochemistry staining, respectively. The sensitivity, specificity, and positive and negative predictive values of hysteroscopy in diagnosing CE were 88%, 89%, 81%, and 95%, respectively. All patients diagnosed immunohistochemically with endometritis 75/200 (37,5%) underwent antibiotic therapy with Ciprofloxacin 500mg 1x2 or Doxycycline 100mg 1x2 for 1 month plus Metronidazole 500mg 1x3 for 10 days, as well as their sexual partners. After completing the antibiotic therapy in 50/75 (66,66%) patients endometritis was no more identified with immunohistochemistry, whereas the rest 25/75 (33,33%) patients needed one or two more courses of antibiotic therapy to have negative immunohistochemistry. Subsequently, 30/75 (40%) patients became pregnant spontaneously, whereas 20/75 (26,66%) with IUI and 21/75 (28%) with IVF. 60/71 (84,5%) patients achieved life births, whereas 11/71 (15,49%) experienced miscarriage.

Conclusions

Hysteroscopy with immunohistochemistry can reliably diagnose chronic endometritis in infertile women and help them to improve their fertility outcomes.

Free communication: Laparoscopic cervical cerclage: indications in highly selected cases and pregnancy outcomes

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Background

Cervical insufficiency (CI) affects approximately 1% of pregnancies and is a significant cause of second-trimester pregnancy loss and preterm birth. Laparoscopic cerclage (LC) is an emerging alternative in women with failed transvaginal cerclage, anatomical cervical limitations, or recurrent pregnancy loss. Compared to open abdominal, the laparoscopic approach offers reduced morbidity and shorter hospitalization whereas compared to transvaginal approaches potentially more favorable reproductive outcomes.

Recent evidence supports its use, particularly when placed preconceptionally, demonstrating lower rates of pregnancy loss and preterm delivery in high-risk populations. Five cases of LC are presented discussing the indications and post-surgical reproductive outcome.

Methods

Five cases of patients with cervical insufficiency due to prior cervical conization were presented. All cases had a history of 1 up to 3 second trimester pregnancy losses. Three cases presented with extremely short cervical length and their previous miscarriages were supported unsuccessfully conservatively (progesterone administration and / or tocolytics plus bed rest); in the rest two others unsuccessful transvaginal cerclage were applied.

A Shirodkar suture at the cervico-isthmic junction was placed, preconceptionally in all cases. A Hegar dilator of 8mm was placed in the cervix during the cerclage to secure an opening of the cervical canal for future 1st trimester miscarriage. No complications were reported, and discharge was made the following day. Informed and written consent for presenting and publishing has been obtained from all patients.

Results

Three cases conceived spontaneously and had term deliveries with cesarean section (38/40 2950gr / 37/40 2740gr/ 39/40 3270gr). One of them experienced a first trimester miscarriage after the cerclage and treated successfully with vacuum aspiration through the cervix. One patient underwent IVF/ET with single embryo transfer and delivered at term a healthy embryo (38/40 weeks, 2950gr). The last patient underwent three failed single embryo-transfers and despite our recommendation for only single ET, she underwent a fourth ET with two embryos resulting in a twin pregnancy. The patient experienced premature rupture of the membranes at 21 weeks of the sac close to the cervical os. She was hospitalized under IV antibiotic treatment and tocolytic therapy. At 26th week of gestation fetal death of the first twin was observed and a planned cesarian section was performed resulting in a healthy alive female of 850gr and a stillborn male of 750gr. The neonate discharged two

months later from the NICU in good health. In all patients, the secure remained at place during the CS for a future pregnancy.

Conclusions

Laparoscopic abdominal cerclage is the preferred approach in cases with refractory cervical insufficiency especially those with extremely short cervix. Previous second trimester abortions unsuccessfully supported either conservatively or with transvaginal cerclage represent an absolute indication for laparoscopic cerclage with favorable reproductive outcomes.

Free communication: Comparison of the effects of V-NOTES and laparoscopic tubal ligation on sexual function

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Background

To compare the sexual functions of patients who underwent tubal ligation with the V-NOTES method and those who underwent Laparoscopic Tubal Ligation.

Methods

48 patients who underwent tubal ligation for contraceptive purposes between January 2024 and March 2025 were evaluated. The patients were divided into two groups as V-NOTES group and Laparoscopic Tubal Ligation (LTL) group. Preoperative and postoperative 6th month demographic data, visual analog scale (VAS) dyspareunia score, female sexual function index (FSFI) total scores and FSFI subparameter scores of these two groups were evaluated retrospectively. Endometriosis, adenomyosis, myoma uteri, presence of systemic disease, presence of autoimmune disease and history of vaginismus were used as exclusion criteria. 9 patients were excluded from the study due to exclusion criteria and 7 patients were excluded due to insufficient data. The Kolmogorov-Smirnov test was used to determine the normalcy of the analysis. The independent test was used to compare the pair groups in the study data evaluation, the matched test was used to ascertain the changes that occurred before and after the treatment. A p-value of less than 0.05 was deemed statistically significant.

Results

The mean age of the patients was 37.9 ± 1.4 , the mean body mass index was $24.1 \pm 1.9 \text{ kg/m}^2$, and no difference was found between the groups. At the 6th month follow-up, VAS (dyspareunia) score was found as 3.9 ± 0.5 in the V-NOTES group and 3.5 ± 0.5 in the LTL group and was found to be significantly higher in the V-NOTES group ($p < 0.05$). When the groups were evaluated within themselves, a significant increase in VAS (dyspareunia) score was detected in the 6th month follow-up in V-NOTES group ($p < 0.05$). At the 6th month follow-up, FSFI score was found as 27.3 ± 3.4 in the V-NOTES group and 28.1 ± 3.6 in the LTL group and was found to be significantly higher in the LTL group ($p < 0.05$). When the groups were evaluated within themselves, a significant decrease in FSFI score was detected in the 6th month follow-up in V-NOTES group ($p < 0.05$). At the 6th month follow-up, satisfaction score was found as 4.3 ± 0.4 in the V-NOTES group and 4.7 ± 0.5 in the LTL group and was found to be significantly higher in the LTL group ($p < 0.05$).

Table 1. Demographic characteristics of the groups

	V-NOTES Group(n:15)	LTL Group(n:17)	p
mean \pm SD			
Age	38 \pm 1.3	37.8 \pm 1.4	0.72
BMI	24.1 \pm 1.8	24.2 \pm 1.6	0.76
Gravidity	2.1 \pm 1.4	2.2 \pm 1.3	0.68
Parity	1.7 \pm 0.9	1.8 \pm 0.8	0.42
*BMI: Body mass index, LTL: Laparoscopic Tubal Ligation			

Conclusions

Although the V-NOTES method may provide cosmetic benefits compared to laparoscopic tubal ligation, it may have negative effects on sexual function secondary to scar tissue in the operation area.

Free communication: bFGF-loaded multilayer collagen scaffolds promote functional uterine regeneration

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Background

Uterine damage often leads to permanent functional impairment due to limited regenerative capacity. While bioengineering approaches have shown promise in endometrial repair, large full-thickness uterine defects remain a significant challenge. This study aimed to develop a cell-free, multi-layer collagen scaffold loaded with collagen-binding basic fibroblast growth factor (bFGF) to reconstruct extensive uterine defects in rabbits and evaluate its ability to restore uterine structure and support live births.

Methods

A sandwich-structured, three-layer collagen scaffold was designed, with smooth layers to guide epithelial growth and a porous middle layer to promote cell infiltration, stromal cell growth and vascularization. bFGF was crosslinked onto the scaffold to enhance regenerative capacity. A 5 cm full-thickness uterine defect was created in rabbits and repaired with either the bFGF-loaded scaffold (bFGF-scaffold group), scaffold alone (scaffold group), or subtotal excision-only group. Structural regeneration was assessed via histology, immunohistochemistry (IHC) at 1, 3, and 6 months post-transplantation. Functional evaluation included natural mating, pregnancy outcomes, and live birth rates.

Results

The scaffold exhibited high collagen type I content and supported rapid tissue ingrowth. At 6 months, the bFGF-scaffold group showed near-normal uterine architecture, with organized epithelium, stroma, smooth muscle bundles, and vascularization, while the scaffold group had incomplete muscle regeneration and the excision group only exhibited fibrosis. Endometrial thickness, gland density, and vascularization in the bFGF-scaffold group matched normal controls ($P>0.05$), whereas the scaffold group remained inferior ($P<0.05$). RNA sequencing revealed enhanced immune regulation and cell proliferation in the bFGF-scaffold group, supported by higher Ki67 expression. Pregnancy rates in the bFGF-scaffold group (50%) were significantly higher than in the scaffold group (30%) and comparable to normal controls (100%, $P>0.05$). All pregnancies in the bFGF-scaffold group resulted in live births. However, the average number of fetuses and live births per pregnancy were significantly lower than in controls.

Conclusions

The bFGF-loaded collagen scaffold successfully reconstructed large full-thickness uterine defects without exogenous cell implantation, restoring near-normal uterine structure and supporting live births. This cell-free approach overcomes limitations associated with seed cell availability, offering a clinically translatable strategy for uterine regeneration.

Free communication: Linzagolix rapidly improves heavy menstrual bleeding and anaemia in women with uterine fibroids: A post-hoc analysis of the PRIMROSE 1 and 2 trials

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Background

Linzagolix is an oral GnRH antagonist shown to significantly reduce heavy menstrual bleeding (HMB) in women with uterine fibroids in the PRIMROSE 1 and 2 trials. This analysis aimed to assess the rapidity of linzagolix in achieving clinically significant HMB reduction (within 4 weeks of initiation) and its ability to sustain this effect through 24 weeks. Additionally, improvements in anaemia and iron deficiency biomarkers were evaluated.

Methods

Pooled data from two similarly designed Phase 3 studies (PRIMROSE 1 & 2; n=1,012) were analysed. Eligible women were randomised equally into five arms: linzagolix 100 mg or 200 mg, with or without add-back therapy (ABT; 1 mg oestradiol / 0.5 mg norethisterone acetate), or placebo. Kaplan-Meier plots adjusted for race and study were used to compare cumulative incidence of achieving and maintaining clinically significant HMB reduction through week 24. In patients who were anaemic at baseline (Hb <12 g/dL; n=662), anaemia improvement was defined as either an Hb increase ≥ 2 g/dL or achieving Hb ≥ 12 g/dL by week 4 and maintaining this through week 24.

Results

Linzagolix treatment led to a significantly faster onset of clinically significant HMB reduction compared with placebo. Median time to sustained HMB reduction was 3 days for linzagolix 200 mg with or without ABT, 12 days for 100 mg with ABT, and 135 days for 100 mg without ABT; the endpoint was not reached in the placebo arm ($p < 0.001$ for all linzagolix arms). Linzagolix-treated women also had higher anaemia response rates and greater improvements in anaemia and iron deficiency biomarkers over 24 weeks. Mean increases in haemoglobin ranged from 1.17–2.08 g/dL in linzagolix arms vs 0.52 g/dL with placebo; mean increases in MCV ranged from 3.37–5.18 fL vs 1.74 fL, and log-ferritin from 128–213% vs 114% ($p < 0.05$ for 9 of 12 treated vs placebo comparisons).

Conclusions

Linzagolix was associated with a rapid and sustained reduction in clinically significant HMB in women with uterine fibroids, with median onset of treatment effect within 4 weeks for most doses. These benefits were maintained through 24 weeks. In anaemic women, linzagolix also led to greater and faster improvements in Hb and iron biomarkers than placebo. These findings support linzagolix as a novel medical treatment approach for symptomatic uterine fibroids, where a rapid and sustained control of HMB and concurrent improvement in anaemia is required.

Free communication: Outcomes of linzagolix in women with concurrent Endometriosis and Adenomyosis: A post-hoc analysis of the EDELWEISS 3 and 6 trials

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Background

Endometriosis and adenomyosis are chronic gynaecological disorders that frequently co-exist, exerting a considerable impact on women's health and quality of life. Endometriosis is characterized by the presence of endometrial-like tissue outside the uterus, while adenomyosis involves the infiltration of endometrial tissue into the myometrium. Although pathologically distinct, both conditions often present with overlapping symptoms—primarily dysmenorrhoea (DYS) and non-menstrual pelvic pain (NMPP)—and their coexistence poses additional diagnostic and therapeutic complexity. This post-hoc analysis of the EDELWEISS-3 and EDELWEISS-6 trials aimed to evaluate the efficacy of linzagolix in women with endometriosis-associated pain (EAP), comparing outcomes in those with endometriosis alone (Endo) versus those with concurrent adenomyosis (Endo+Adeno).

Methods

EDELWEISS-3 was a multicenter, randomized, double-blind, placebo-controlled phase 3 trial assessing linzagolix for EAP in reproductive-age women with surgically confirmed endometriosis within the past 10 years. Participants with concurrent adenomyosis detected via transvaginal ultrasound (TVUS) were included, provided their adenomyosis did not interfere with EAP assessment. Subjects were randomized to linzagolix 200 mg with hormonal add-back therapy (ABT; 1 mg estradiol/0.5 mg norethisterone acetate), linzagolix 75 mg, or placebo for six months. Participants could then continue in the EDELWEISS-6 extension study for an additional six months, with placebo-treated patients re-randomized to either linzagolix dose.

Co-primary endpoints were a clinically meaningful reduction in DYS and NMPP at 3 and 12 months, with stable or decreased analgesic use. Symptom severity was evaluated daily using a four-point verbal rating scale. Outcomes were compared between the Endo and Endo+Adeno subgroups.

Results

Of 484 women enrolled, 145 (30%) had concurrent adenomyosis. In the linzagolix 200 mg+ABT group, 78.4% of Endo+Adeno patients achieved a clinically meaningful reduction in DYS at three months (OR: 11.24, $p<0.001$), compared with 69.5% of Endo patients (OR: 7.01, $p<0.001$), with sustained benefit through 12 months. In contrast, the linzagolix 75 mg group showed significant improvement only in the Endo subgroup (47.3%; OR: 2.75, $p<0.001$), with a non-significant response in the Endo+Adeno group (34.8%; OR: 1.65, $p=0.566$).

For NMPP, linzagolix 200 mg+ABT improved symptoms in 47.6% of Endo patients (OR: 2.05, $p=0.021$) and 49% of Endo+Adeno patients (OR: 1.92, $p=0.243$) at three months. By six months, significant improvements were observed in both subgroups ($p=0.026$ and $p=0.034$, respectively), maintained

through 12 months. Linzagolix 75 mg did not result in significant NMPP improvements at three months in either group.

Conclusions

Linzagolix 200 mg+ABT, but not 75 mg, significantly improved DYS in women with concurrent endometriosis and adenomyosis. These findings support the potential benefit of higher-dose linzagolix for this patient population and warrant further investigation.

Non-invasive neovagina creation using vaginal dilation therapy in 97 patients with Mayer-Rokitansky-Küster-Hauser syndrome

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Background

Mayer-Rokitansky-Küster-Hauser (MRKH) syndrome is a congenital malformation of the female reproductive tract, characterized by the absence of a uterus and upper vagina. Non-invasive vaginal dilation therapy has been recommended as the first-line choice for neovagina creation due to the high success rate, minimal risk of complications, and cost-effectiveness. This study reports a case series including 97 MRKH patients who underwent vaginal dilation therapy, supported by offline and online resources from an experienced multidisciplinary team.

Methods

This single-center study was conducted at Peking Union Medical College Hospital, China. Ninety-seven patients who decided to commence vaginal dilation were enrolled after the introduction of various treatment options. After receiving baseline assessment and hands-on teaching, patients returned home with educational materials and performed dilation by themselves. Patients went back to the clinic at 1, 3, 6, and 12 months. Monthly questionnaires were administered to gather data on dilation frequency, current vaginal length, sexual function, and complications. For patients with sexual intercourse, success (functional success) was defined as a Female Sexual Function Index (FSFI) total score > 23.45, the cut-off score of normal sexual function in Chinese population. For patients without sexual intercourse, success (anatomical success) was defined as neovaginal length > 6 cm.

Results

Successful neovagina creation occurred in 77% (75/97) patients, with a median time of 91 (71–130) days. Among the 97 patients, 45 had sexual intercourse, of whom 89% (40/45) achieved functional success; 52 patients didn't have sexual intercourse, of whom 67% (35/52) achieved anatomical success. The vaginal length in the 75 successful patients increased from 1.0 (1.0, 3.0) cm to 7.0 (6.0, 8.0) cm by the end of follow-up. Patients with sexual intercourse had significantly longer neovaginas than those without (8.0 [7.0, 8.0] cm vs. 7.0 [6.0, 7.0] cm, $p = 0.003$). Twenty-two patients failed, with a median vaginal length of 5.0 (5.0, 5.0) cm. Nine unmarried patients without sexual partners lacked motivation and gave up dilation. Four patients opted for surgery because of upcoming marriage plans and the urgent need for a "normal" vaginal appearance. Contact was lost with the other six patients. Significant factors associated with successful dilation included having a sexual partner, engaging in sexual intercourse during dilation, and receiving support from the sexual partner. Multivariate logistic regression analysis identified engaging in sexual intercourse during dilation as an independent predictor for success (odds ratio 3.26, 95% CI 1.05–10.11, $p = 0.041$). Patient-reported complications included vaginal pain (61/97), vaginal spotting (48/97), anal pain (27/97), urinary infection (20/97), and uriesthesia during dilation (7/97), mostly at the start of the dilation procedure.

Conclusions

Self-dilation with online support from an experienced multidisciplinary team is effective in MRKH patients. Sexual intercourse and the involvement of sexual partners can contribute to the success of dilation treatment.

Free communication: Stratified Management of Retained Products of Conception: A Retrospective Cohort Study on Therapeutic Efficacy

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Background

Retained products of conception (RPOC) following first-trimester pregnancy termination represent a clinically significant condition that may adversely affect endometrial receptivity and subsequent reproductive potential. This investigation evaluates a stratified recommendation incorporating ultrasonographic residual tissue volume, serum β -human chorionic gonadotropin (hCG) concentrations, and comparative surgical approaches to optimize clinical management.

Methods

A retrospective cohort analysis was conducted from November 2023 to October 2024, enrolling 201 consecutive patients with sonographically confirmed RPOC (persistence ≥ 2 weeks post-procedure) following first-trimester termination. Inclusion criteria mandated hemodynamic stability without evidence of active hemorrhage or pelvic infection. Therapeutic allocation was determined through shared decision-making incorporating patient preferences and clinical parameters. Stratification was performed according to residual diameter (≤ 2 cm versus > 2 cm) and serum hCG concentration (≤ 200 IU/L versus > 200 IU/L).

Interventional modalities comprised:

1. Pharmacological management (n=89): Cyclic estrogen-progestin therapy (28-day regimen) with optional adjunctive mifepristone (150mg single-dose)
2. Surgical intervention (n=112): Hysteroscopic resection under intracavitary visualization, utilizing mechanical grasping forceps (n=42), monopolar electrosurgical loop (n=43) and rotary morcellation (n=27).

Primary endpoints evaluated at first post-interventional mid-luteal phase included: Therapeutic success (complete sonographic resolution); Endometrial trilaminar thickness measurement; Incidence of intrauterine adhesions (classified per ASRM criteria) Secondary endpoints assessed 6-month reproductive outcomes.

Statistical analyses employed χ^2 tests for categorical variables and one-way ANOVA with Tukey post-hoc correction for continuous measures ($\alpha=0.05$).

Results

Pharmacological intervention demonstrated significantly greater efficacy for minimal residuals (≤ 2 cm: 44.3% [27/61] versus > 2 cm: 18.8% [5/28]; RR 2.36, 95%CI 1.52-3.65, $p<0.001$), while serum hCG concentrations showed no prognostic value (≤ 200 IU/L: 36.6% [15/41] versus > 200 IU/L: 38.5% [17/44], $p=0.86$).

Surgical outcomes revealed: Residual tissue persistence (3.6% [4/112]), followed by the expectant management (n=1) or a cycle of estrogen-progestin therapy (n=3); Endometrial parameters favored

medical therapy (mean thickness: 9.1 ± 1.2 mm versus surgical: 8.3 ± 1.5 mm; mean difference 0.8 mm, 95% CI 0.1-1.5, $p=0.04$). Significant variance in adhesion formation by technique (morcellation: 0% versus conventional methods: 7.0-9.5%, $p=0.04$); Conception rates trended higher with morcellator while with non-significant trend (70.4% versus 52.4-60.5%, $p=0.12$). Overall conception rates showed no significant intergroup difference (43.8% versus 56.2%, $p=0.08$). Five of seven adhesion cases required hysteroscopic adhesiolysis, with one subsequent conception.

Conclusions

This risk-adapted protocol successfully individualized RPOC management, with pharmacological therapy demonstrating endometrial preservation advantages for limited residuals, while surgical modalities effectively addressed more substantial retention. The absence of adhesions and superior reproductive outcomes associated with morcellation suggest its preferential consideration when operative intervention is indicated. These findings support the implementation of ultrasound-guided therapeutic stratification to optimize both immediate resolution and future reproductive potential.

Free communication: Single Port Robotic Surgery for Early-Stage Endometrial Cancer: preliminary data of a pilot study.

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Background

Endometrial cancer (EC) is the second most common gynecologic malignancy worldwide. In early-stage disease, minimally invasive surgery (MIS) plays a pivotal role in this scenario. Robotic assisted surgery (RAS) showed equivalent oncologic outcomes compared to laparoscopy while improving learning curves, surgeon comfort and precision.

Methods

This study describes the feasibility, safety, and perioperative outcomes of RAS for EC using the da Vinci SP™ system (Intuitive Surgical, Sunnyvale, CA, USA) recently introduced in Europe for gynecologic procedures. 10 consecutive patients were selected to undergo RAS surgical staging with da Vinci SP™ for early-stage EC. Perioperative outcomes as well as intra and post-operative complications were prospectively recorded. All patients after pre-operative workup consisting in diagnostic hysteroscopy, computed tomography and MRI underwent radical surgery (type A radical hysterectomy, bilateral salpingo-oophorectomy and bilateral sentinel lymph-node (SLN) dissection).

Results

All patients successfully underwent minimally invasive surgery, only one conversion to open surgery for specimen integrity and retrieval was reported. In 4 cases, unilateral pelvic lymphadenectomy was required due failed SNL detection, three of whom had positive lymph nodes on definitive histologic examination. Median estimated blood loss was 50 mL (range 50–250 mL), and median operative time was 127 minutes (range 116–172 minutes). No major intraoperative complications were reported, and postoperative recovery was uneventful.

Conclusions

This preliminary data of this pilot study, suggested the feasibility and high reliability of single-port RAS, showing its potential and representing a promising tool for the minimal invasive management of Endometrial Cancer.

Free communication: Time for innovation. Our experience with AVETA, the first single-use Hysteroscopic Tissue Removal System.

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Background

In 2011, the first hysteroscopic tissue removal system (HTRS) designed for office setting was launched.

14 years later, we presented the results of the first hysteroscopies performed at our hospital using AVETA, an innovative single-use HTRS with several specific features.

The hysteroscope integrates a wide-angle HD camera and a LED light in the tip as well as controls that allow us to fully control the management of fluids.

The hysteroscope diameters are the smallest currently available (between 4.6 and 5.7 mm), but they allow the insertion of working elements between 2.9 and 4 mm with 7 and 8 mm windows thanks to an expandable tip system that allows access to the cavity with a reduced diameter.

It also features an integrated camera rotation system that eliminates awkward tubing management, an automatic upright image orientation-lock for seamless visualization and an advanced fluid management system with improved pressure and fluid deficit control.

Methods

A retrospective longitudinal study of the procedures performed in office setting between September 2024 and May 2025 in our hospital using the AVETA HTRS was conducted

Results

A total of 263 hysteroscopies were performed.

In 145 cases, a total polypectomy, whether single or multiple, was performed. No cases of partial resection were recorded.

Myomectomy was performed in 58 cases: in 44 cases, total myomectomy was performed in a single procedure; in 6 cases, due to the complexity of the fibroids, two or three steps were required, and in 6 cases, resection was incomplete. Two patients are currently awaiting a second stage to complete

the resection.

A visual Dilatation & Curettage was performed for suspected malignancy in 19 cases, and in 12 cases as follow-up after a diagnosis of adenocarcinoma or endometrial intraepithelial neoplasia (EIN) in patients with unfulfilled desire for childbearing or medical conditions that contraindicates surgery.

In 6 cases, retained products of conception (RPoC) resection were performed.

There were no cases in which the cavity could not be accessed, and only in 1 case the hysteroscopy was classified as unsatisfactory due to inability to distend the cavity.

Tolerance was good in 94.7% of cases, with a mean visual analogue score (VAS) of 2.

Four complications were recorded: 2 cases of suspected unconfirmed perforation requiring admission and 2 cases of fluid overload (deficit -2500 ml), which were resolved with observation without requiring admission or use of diuretics.

Conclusions

Our first experience with the new HTRS is positive. We highlight the ease of access to the cavity, with good tolerance due to the small diameter of the hysteroscope, the good tissue resection capacity thanks to the powerful working elements, the high safety thanks to the fluid control system and the ease of use thanks to improved ergonomics, the lower weight of the hysteroscope and working elements, and good image quality.

Free communication: An evaluation of Web-based versus standard Information for Same day laparoscopic Hysterectomy (WISH): A randomised controlled trial

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Background

Our objective was to evaluate the potential efficacy and feasibility of an additional online, patient education resource for Same Day Discharge Laparoscopic Hysterectomy (SDD LH) compared to standard information alone.

Methods

A pilot randomised controlled trial was conducted to test the feasibility of running a full-scale trial and evaluate the potential efficacy of a novel, online patient education tool (www.mydaycasehysterectomy.com) in achieving SDD following LH. Participating women were randomised to have access to the supplementary on-line educational resource or to receive standard, written pre-operative information. Feasibility outcomes included the proportion of eligible patients based, the number of eligible participants screened and meeting the inclusion criteria and the proportion of eligible patients agreeing to randomisation and adherence to the trial interventions/follow-up. The primary clinical outcome was compliance with SDD and secondary outcomes included utility of pre-operative information and satisfaction (six point Likert scales), acceptability (5 point Likert scale) and quality of life (EuroQol VAS) associated with SDD LH measured at 6 weeks post-surgery and time to resume usual activities (PROMIS-SF) censored after 12 weeks.

Results

60 women were recruited over 12 months (01/03/2024 to 01/03/2025). 2/30 (6.7%) women did not access the educational website, citing technical difficulties or forgetting to do so. 97/132 (73.5%) of patients listed for LH were eligible for SDD LH, 60/97 (62%) of these met the inclusion criteria and all participants agreed to randomisation. All patients adhered to the trial interventions and 58/60 (97%) completed follow-up.

Same day discharge was achieved by 23/30 (77%) women receiving on-line information vs. 19/30 (63%) receiving standard information (RR 0.83, 95% CI 0.59 – 1.16; $P = 0.3$). One patient in each group was lost to follow up and were excluded in post-procedural analysis. Satisfaction with pre-operative information (86% vs 97%) and with overall care (89% vs 93%) was comparable ($p > 0.05$) between groups. All 29 women accessing the educational website found it acceptable and would recommend its use for future patients; 27 (93%) rating it “totally understandable” and two as “generally understandable (7%)”. No significant differences were observed in resumption of usual activities: PROMIS-SF post-hysterectomy at 12 weeks (26.5 [SD 9.0] for access group vs 24.5 [SD 7.5] for no access group; $P=0.4$).

Conclusions

Conduct of a full-scale RCT evaluating bespoke, on-line patient educational information about SDD LH is feasible. Provision of such web-based information prior to surgery appears to be acceptable and useful to women, and may optimise compliance with SDD as well as enhance patient satisfaction with care.

Fibroid Mapping Voluson™: a novel tool for preoperative evaluation of uterine fibroids. A case series.

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Background

Uterine fibroids are common benign tumors affecting women of reproductive age and often require surgical treatment such as myomectomy. Accurate preoperative mapping is crucial for optimal surgical planning and outcomes. Conventional ultrasound techniques may be limited in precisely locating and characterizing fibroids, particularly in complex cases and multiple myomas. The Fibroid Mapping Application, developed by the GE Voluson™, is an Artificial Intelligence (AI)-integrated tool aiming at standardizing the documentation process by mapping, measuring, classifying fibroids and finally generating real-time 3D images. The Fibroid Mapping Application aids in creating detailed surgical plans, helping to prevent missed fibroids and reduce unnecessary damage during surgery. In light of all this, in this study, we present a series of cases demonstrating the utility, innovation and ease of use of the Fibroid Mapping Application as a pre-surgical planning tool for uterine fibroids.

Methods

A case series was conducted on 30 reproductive-age women diagnosed with uterine fibroids at two centers: University “Federico II” of Naples, Italy, and KU Leuven, Belgium. All patients underwent laparoscopic or robotic-assisted myomectomy between March 2024 and March 2025, with hysteroscopic myomectomy added for submucous fibroids when necessary. Preoperative evaluation included anamnesis, clinical examination and 2D/3D transvaginal ultrasound using Voluson™ Signature (Naples) and Voluson™ Expert 22 (Leuven) systems, both equipped with the Fibroid Mapping Application. The tool identified and characterized fibroids based on location, FIGO classification, size, echogenicity, vascularization, and provided 3D-rendered uterine maps to assist in surgical planning. All scans were performed within 30 days before surgery. Intraoperatively, surgeons assessed the correspondence between preoperative imaging and surgical findings using a 4-point rating scale: very poor, poor, good, and optimal. All patients underwent follow-up imaging with the same tool 30 days post-surgery.

Results

Across the 30 patients, 129 fibroids were identified preoperatively. Intraoperative correlation was rated *optimal* in 24 cases and *good* in 6 cases. Mapping accuracy was slightly reduced in cases

involving large uteri ($>300\text{ cm}^3$) and pedunculated fibroids (FIGO Type 7), where fibroid mobility and distortion limited visualization. No major intraoperative or postoperative complications were reported. Follow-up imaging effectively identified small ($<2\text{ cm}$), intramural fibroids (FIGO Type 4) that were not removed during surgery, demonstrating the application's utility in postoperative monitoring.

Conclusions

The Fibroid Mapping Application offers a promising advance in the preoperative assessment of uterine fibroids, providing accurate, real-time imaging and 3D visualization to guide surgical planning. It performed reliably across a range of fibroid types and locations, with minor limitations in cases involving large uterine volumes or pedunculated fibroids. The tool also proved valuable for post-surgical surveillance. Larger-scale studies are needed to further validate its diagnostic performance and potential for widespread clinical use.

Free communication: What Shapes a Surgeon? Comparative Analysis of Performance in GESEA LASTT exercises among medical students: influence of sex, hand laterality, and hobbies

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Background

The Gynaecological Endoscopic Surgical Education and Assessment (GESEA) program provides a structured approach to develop laparoscopic skills. However, the extent to which individual characteristics influence learning outcomes remains unclear. This study aims to assess the improvement in laparoscopic performance among medical students who participated in the Laparoscopic Skills Training (LASTT) program at Università Cattolica del Sacro Cuore in Rome (Gemelli Hospital). Specifically, we analyze whether performance varies based on future career preferences (surgical vs. medical fields), gender, hand laterality, and hobbies.

Methods

A prospective observational study was conducted on a cohort of 181 medical students. The participants' age ranged from 23 to 26 years, with 87 females and 94 males. Participants completed two standardized laparoscopic exercises ("Camera navigation" and "Hand-eye coordination"), each performed three times. Their progression was analyzed to identify potential differences in skill acquisition related to their professional aspirations, gender, hand laterality, and hobbies. Statistical analysis was performed using the chi-square test to compare exercise completion rates, and the Mann-Whitney U test to compare exercise completion times.

Results

In both exercises the success rate improvement and the average time (for those who successfully completed the exercise) are better for the 139 surgical participants than for the 43 medical ones (without a statistical significance). There aren't differences in success rates between those who have or have not attended the operating room, but paradoxically, those who have not attended are on average faster in a nearly statistically significant way ($p = 0.065$). No statistically significant difference emerges when comparing males/females and those who do or do not play video games. Right-handed individuals have a statistically significantly higher success rate compared to left-handed individuals ($p = 0.0002$ in the third attempt of the first exercise and $p = 0.016$ in the first attempt of the second exercise). However, surprisingly, among those who successfully complete the exercise, left-handed individuals have a better average time than right-handed individuals, although without statistical significance. For those who play a musical instrument, we discovered that there is a in average times in both exercises compared to those who do not play instruments (not statistically significant). Finally, in the group that practices precision sports, there is a statistically significantly higher success rate compared to those who do not ($p = 0.0087$ in the third attempt of the second exercise).

Conclusions

Right-handed individuals have higher success rates than left-handed individuals (even if they are generally slower). Those who practice a precision sport have a higher success rate than those who do not.

FREE COMMUNICATIONS

ESGE34-1039 -

Free Communication

Pregnancy in isthmocele

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Background

A clinical case of pregnancy after surgery and successful gestation of pregnancy complicated by implantation of the fertilized egg in the isthmocele (uterine scar after cesarean section) is presented. An approach to isthmocele correction using combined hysteroscopic and laparoscopic access, including metroplasty, is described.

Methods

Hysteroscopically, we confirmed that the localization of the fertilized egg was in the area of the uterine scar. An obvious defect was determined. Methotrexate was injected with a special needle, inserted intrathecally (into the gestational sac). Next, the laparoscopic stage of the operation is presented.

Results

The patient was under observation. A control ultrasound examination was performed at 3 and 6 months to assess the condition of the scar on the uterus. The suture looked very good, without a defect, with a wall thickness of 8 mm.

Conclusions

After 7 months, a spontaneous pregnancy occurred. At 38 weeks, a planned surgical delivery was performed.

<https://player.vimeo.com/video/1092419983?autoplay=1>

Laparoscopic oophoropexy for recurrent ovarian torsion: Technique of utero-ovarian ligament shortening and fundal fixation

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Background

Recurrent ovarian torsion is an uncommon but serious condition that poses a risk of ovarian dysfunction, particularly in young women. Anatomical variations such as elongated utero-ovarian ligaments may predispose to recurrence. Preventive surgical strategies, including oophoropexy, are critical to minimize recurrence and preserve fertility.

Methods

A 24-year-old woman with a history of three prior laparoscopic detorsions presented with acute left lower quadrant pain. Laparoscopy revealed a torsed left ovary with venous congestion but preserved viability. The utero-ovarian ligament was noted to be abnormally elongated. Following gentle detorsion and confirmation of reperfusion, oophoropexy was performed using a non-absorbable Prolene® suture. The ovary was anchored to the posterior uterine fundus to restrict mobility and effectively shorten the utero-ovarian ligament.

Results

The procedure was completed laparoscopically without intraoperative complications. The patient had an uneventful postoperative recovery and was discharged on the first postoperative day. At follow-up, she reported no recurrence of symptoms, and pelvic ultrasonography confirmed normal ovarian morphology and blood flow.

Conclusions

Laparoscopic oophoropexy with fixation to the posterior uterine fundus is a safe, effective, and fertility-preserving approach for managing recurrent ovarian torsion due to ligamentous laxity. This technique offers stable anatomical support and may significantly reduce the risk of recurrence. Early identification of anatomical risk factors and individualized surgical planning are key to optimizing outcomes.

<https://player.vimeo.com/video/1090169833?autoplay=1>

Bilateral Tubal Torsion in a Case of Bilateral Hydrosalpinx: A Rare Cause of Acute Pelvic Pain

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Background

Isolated fallopian tube torsion is a rare clinical entity, with an estimated incidence of 1 in 1.5 million women, while bilateral torsion of the fallopian tubes is extremely rare. Tubal torsion accounts for 1–3% of cases initially presumed to be ovarian torsion and often presents with non-specific symptoms and unremarkable imaging. Reports of bilateral tubal torsion are extremely scarce in the literature, particularly in women without prior pelvic surgery or infection. Early diagnosis is crucial to prevent irreversible ischemic damage, and laparoscopy remains the gold standard for both diagnosis and treatment.

We report the case of a 37-year-old, G1P1, with previously diagnosed bilateral hydrosalpinx. She presented to the ER with acute pelvic pain, nausea, and vomiting unresponsive to medication. Initial work-up revealed no biological signs of inflammation, negative hCG, and negative PCR tests for *Chlamydia trachomatis* and *Neisseria gonorrhoeae*. A CT scan confirmed the presence of bilateral hydrosalpinx and ruled out other potential intra-abdominal causes of the patient's symptoms. Vaginal ultrasound showed a whirlpool sign adjacent to the right ovary, raising suspicion of tubal torsion.

Methods

Patient was prepared for a diagnostic laparoscopy, which revealed bilateral torsion of the fallopian tubes with congested and ischemic appearance, but no ovarian involvement. Patient had no further pregnancy wishes. A bilateral salpingectomy was performed using bipolar energy.

Results

The postoperative course was uneventful. Histological analysis confirmed bilateral hydrosalpinx with ischemic and hemorrhagic changes consistent with torsion.

Conclusions

Bilateral tubal torsion is an exceptionally rare condition, with very few cases reported in the literature. This case highlights the diagnostic challenge in patients with known hydrosalpinx presenting with non-specific symptoms and no inflammatory markers. Recurrent or persistent pelvic pain in such patients should prompt timely surgical exploration to avoid tubal necrosis and complications. Early intervention may preserve fertility in selected cases.

<https://player.vimeo.com/video/1088783200?autoplay=1>

Laparoscopic Management of a Giant Right Paraovarian Cyst with Serous Content: A Case Report

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Background

Paraovarian cysts are typically benign adnexal lesions arising from the mesosalpinx. While most remain small and asymptomatic, giant paraovarian cysts are rare and may present with pressure symptoms or be discovered incidentally.

Methods

We report the case of a 34-year-old nulliparous woman who was referred to our gynecology clinic with complaints of increasing abdominal distension and discomfort over the past several months. Pelvic ultrasonography and MRI revealed a large right-sided paraovarian cyst measuring approximately 18 cm in greatest dimension, with thin walls and anechoic content suggestive of a benign etiology.

The patient underwent laparoscopic cyst excision. Intraoperatively, a thin-walled, translucent cystic structure originating adjacent to the right fallopian tube was identified, consistent with a paraovarian origin. The cyst contained clear serous fluid. The right ovary and fallopian tube were normal in appearance and preserved. The cyst was aspirated and completely excised using laparoscopic instruments without rupture or spillage.

Results

Microscopic examination revealed a unilocular cyst lined by a single layer of flattened to cuboidal epithelium, consistent with a benign serous cyst. The cyst wall was composed of fibrous connective tissue without any papillary projections, cellular atypia, or evidence of malignancy. Immunohistochemical staining was not required due to the characteristic benign features.

Final diagnosis: Benign serous paraovarian cyst.

Conclusions

Giant paraovarian cysts, though rare, can be safely and effectively managed using minimally invasive laparoscopic techniques. Complete excision with preservation of adnexal structures provides definitive treatment and diagnosis. This case underscores the importance of accurate preoperative imaging, surgical planning, and histopathological evaluation.

<https://player.vimeo.com/video/1085655386?autoplay=1>

Indocyanine Green (ICG) Fluorescence-Guided Surgery in Deep Infiltrating Endometriosis: A Cohort Comparison with Ureteric Stenting

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Background

Deep infiltrating Endometriosis (DIE) often involves dense pelvic adhesions and proximity to the ureters, making dissection technically demanding and increasing the risk of ureteric injury. Ureteric stents are commonly used to aid identification but are associated with postoperative discomfort, haematuria, and the need for secondary removal procedures. This study evaluates the role of intraoperative Indocyanine Green (ICG) fluorescence imaging, delivered via ureteric catheters, as an alternative for intraoperative ureteric visualization in complex endometriosis surgery.

Methods

A cohort comparison was conducted at the Royal Stoke hospital, UHNM a BSGE-accredited tertiary referral Endometriosis centre. 17 patients undergoing Laparoscopic or Robotic surgery for Deep Infiltrating Endometriosis received ICG via ureteric catheters. Surgical outcomes and patient-reported experiences were compared with a cohort of 20 patients who underwent similar procedures with ureteric stents. Collected data included demographic variables, intraoperative findings, complication rates, and patient-reported outcomes using EQ-5D and the Surgical Satisfaction Questionnaire (SSQ), assessed at baseline and six to twelve months postoperatively.

Results

The study found no reported ureteric injuries in either group. Patients in the ICG group reported better overall health at 6 to 12 months, with a higher EQ-VAS score (9.0 vs 6.9) and higher EQ-5D scores (0.88 vs 0.72). A significantly higher percentage of ICG patients (82%) returned to usual activities without issues compared to 15% in the stent group. Pain levels were also more favourable in the ICG group, with 41% reporting no pain versus 0% in the stent group; moderate to severe pain was more common in the stent group (25% vs 12%). In terms of postoperative pain control, 94% of ICG patients were satisfied or very satisfied in the hospital compared to 75% in the stent group, and at home, satisfaction was 100% in the ICG group versus 90% in the stent group. Regarding resuming daily activities, 88% of ICG patients were satisfied compared to 20% in the stent group. Satisfaction with return to work was higher in the ICG group (82% vs 40%), as was return to exercise (70.5% vs 40%). Surgical outcome satisfaction was comparable between groups (88% ICG vs 90% stent), though a higher percentage of ICG patients reported being “very satisfied” (65% vs 10%). Furthermore, 94% of ICG patients indicated they would undergo the surgery again, compared to 25% in the stent group, and all ICG patients (100%) would recommend the surgery to others, versus 25% in the stent group.

Conclusions

Indocyanine Green (ICG) fluorescence-guided ureteric visualization is a safe and effective alternative to ureteric stenting in DIE surgery. It offers advantages in postoperative pain control, faster recovery, fewer complications, and superior patient satisfaction. The data strongly support the broader

adoption of ICG-guided techniques and warrant further evaluation of ICG usage in Deep Infiltrating Endometriosis surgery.

Video of Robotic Approach to Parametrial Endometriosis with Segmental Resection: Surgical Standardization and Use of Indocyanine Green for Nerve Preservation and Prevention of Postoperative Complications

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Background

This robotic surgery involves a 37-year-old patient presenting with dyspareunia, dyschezia, and infertility associated with parametrial disease, intestinal involvement, and a desire for fertility preservation. We begin by identifying the anatomical landmarks of the pelvis in order to restore normal anatomy and perform surgical damage control prior to the excision of the disease itself. We then identify the left ureter and create the medial and lateral pararectal spaces. In this robotic case we used 3 robotic arms: one for the camera, one for the monopolar scissors for tissue dissection, and another for the robotic bipolar grasper, with assistance from a 5 mm laparoscopic assistant Port. Next, we proceed with the dissection of the rectovaginal septum, which is one of the most critical steps of the procedure. During this phase, a vaginal and rectal probe can be used to assist the surgeon. After completing the dissection, we observe that the innervation of the inferior hypogastric plexus is preserved. A retrosigmoidectomy was performed, followed by the excision of a vaginal nodule without vaginal opening. The enhanced visualization and robotic instruments allow for safer removal of the vaginal nodule and help avoid multiple sutures, which could increase the risk of fistula formation. An intestinal anastomosis was performed, followed by assessment of intestinal perfusion using indocyanine green and Firefly technology.

Methods

One female patient with endometriosis

Results

Robotic surgery for endometriosis treatment.
Surgery done in one time.

Conclusions

Use of technology can improve results and prevent future complications.

<https://player.vimeo.com/video/1089560886?autoplay=1>

Machine Learning to Identify Pain Status in Endometriosis Patients Using Microbiome Composition

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Background

Endometriosis affects 10% of women and is associated with differing chronic pain mechanisms. Emerging evidence links alterations in gut and reproductive-tract microbiomes to inflammation and pain. The objective of this study was to examine the differences in microbiome profiles in endometriosis patients with and without chronic pelvic pain and or nociplastic pain. We also created machine learning models to identify pain status for patients with endometriosis using microbiome data.

Methods

We collected stool, endometrial, and ovarian cyst biopsies from 12 women with confirmed diagnoses of endometriosis and 8 endometriosis-free controls at laparoscopic surgery. Taxonomic profiles were generated from 16S rRNA gene sequences, denoised, and processed using QIIME2. Patients were further classified by two independent criteria: (1) Nociplastic pain status, defined by the Fibromyalgia Survey Questionnaire, and (2) Chronic pelvic pain status using self-reported visual analog pain scale via REDCap. Shannon alpha diversity and beta diversity of taxa profiles between different patient groups were assessed using the phyloseq package. Differentially abundant genera were identified based on log fold change ($|\log_{10} \text{fold change}| \geq 1$). We created a boosting tree classifier trained on genus-level relative abundances to discriminate between chronic pelvic pain and non-pain groups from the combined in-house cohort and public datasets. The model performance was evaluated by area under the receiver operating characteristic curve (AUROC).

Results

We found that microbiome composition varied strongly by sample types as expected, with stool samples dominated by *Bacteroides*, while the ovarian cyst and endometrium samples were enriched in *Vibrio* and *Halomonas* in both patients and control groups. In endometrial samples, we noticed that alpha diversity was significantly lower in patients with nociplastic pain, dominated by *Vibrio*, *Sphingomonas*, and *Lactobacillus* (Shannon index, $p = 0.03$). Differential taxa analysis identified genera enriched in each group across the three sample types. In the nociplastic pain group, we observed decreased abundances of *Rhizobium sensu lato* in endometrial samples, *Streptococcus* in cyst tissue, and *Faecalibacterium* in stool; however, these differences were not statistically significant after adjustment ($p > 0.05$). Despite non-significant statistical outcomes, our predictive results indicated our model achieved decent performance (Accuracy = 0.74, Recall = 0.71, AUROC = 0.84) for identifying chronic pelvic pain status in women with endometriosis using the combined dataset. *Bacteroides*, *Bulleidia*, and *Butyricimonas* are identified as most important predictive genus by the boosting tree models.

Conclusions

We identified that microbiome diversity in endometrial samples was significantly associated with nociplastic pain status in endometriosis patients. Sample-type-specific microbiome signatures were correlated with chronic pelvic pain and nociplastic pain phenotypes in endometriosis patients. We further demonstrated the utility to predict chronic pelvic pain status in endometriosis patients with machine learning models using microbiome components. Future studies should determine what microbiome metabolomic products are important in endometriosis associated chronic pelvic pain.

Impact of central sensitization on the response to hormonal therapy in women with endometriosis: a prospective study.

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Background

A subset of patients receiving hormonal therapy for endometriosis remain symptomatic, suggesting that factors beyond endometriosis, such as central sensitization (CS), contribute to pain persistence. The Central Sensitization Inventory (CSI) is a validated self-report questionnaire to assess CS symptoms; a CSI score ≥ 40 has been reported effective to identify patients with CS among women with chronic pelvic pain. This study aimed to evaluate the impact of the CSI score on persistence of moderate-to-severe pain after hormonal therapy in women with endometriosis.

Methods

This single-center, prospective observational study was conducted at a tertiary referral center for endometriosis (Human Reproduction Physiopathology, Azienda Ospedaliero-Universitaria di Bologna, Italy). Consecutive symptomatic patients aged 18–50 years with diagnosed endometriosis, not having received hormonal therapy for at least 3 months and attending the outpatient clinic from January to April 2024 were enrolled. All patients provided informed consent to participate in the study. At baseline (T0), pain intensity related to chronic pelvic pain (CPP), dysmenorrhea, deep dyspareunia, dyschezia and dysuria was assessed using an 11-point Numerical Rating Scale (NRS). The CSI questionnaire was administered, and hormonal therapy was prescribed, including estroprogestins (cyclic or continuous), progestins or levonorgestrel-releasing intrauterine system (LNG-IUS). At 6 months (T1), adherence to therapy and pain scores were reassessed. Pain persistence was defined as no improvement of at least one NRS severity category (<4 mild, 4–6 moderate, ≥ 7 severe) between T0 and T1.

Results

Among 114 enrolled patients, 46 (40.4%) had a CSI score ≥ 40 . At baseline, patients with CSI ≥ 40 showed a higher prevalence of moderate-to-severe pain, especially chronic pelvic pain, deep dyspareunia and dyschezia, with statistically significant differences compared to women with CSI score < 40 . Univariate analysis identified higher CSI scores (OR 7.54, 95% CI 2.94–18.86, $p < .001$), non-caucasian ethnicity (OR 2.95, 95% IC 1.29–6.78, $p = 0.01$), baseline CPP (OR 11.4, 95% IC 5.14–25.29, $p < .001$) and multiple CS syndromes (OR 1.36, 95% IC 1.01–1.82, $p = 0.04$) as factors associated with persistent chronic pelvic pain; continuous hormonal therapy was protective (OR 0.27, 95% IC 0.07–0.98, $p = 0.048$). Multivariate analysis confirmed CSI score (OR 4.17, 95% IC 1.25–13.8, $p = 0.02$) and severe baseline pain (OR 13.52 95% IC 4.84–37.78, $p = < 0.001$) as independent predictors of pain

persistence, with continuous therapy maintaining its protective effect (OR 0.07 95% IC 0.01-0.45, $p = 0.005$). Higher CSI scores also predicted therapeutic failure at multivariate analysis in dyschezia (OR 5.35, 95% IC 1.91-15.05, $p = 0.001$) and deep dyspareunia (OR 6.10, 95% IC 2.58-14.41, $p < 0.001$).

Conclusions

Central sensitization is common among patients with endometriosis and is a key contributor to pain persistence and treatment resistance. Early identification of CS may guide personalized, multimodal treatment strategies.

Clinical use of indocyanine green for optimizing ureteral resection in ureteric endometriosis

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Background

In this video, we describe the use of ureteral indocyanine green for identification of the ureteral deep endometriosis lesion and determine the limit of resection

Methods

Surgical video case

Results

A 34-year-old lady with complains of primary infertility and severe pelvic pain syndrome. She had undergone a laparotomy for endometriosis. MRI revealed adenomyosis, deep endometriosis in the uterosacral ligaments and in the left parameter. The left ureter is dilated, with altered patency and hydronephrosis stage III. Intravenous urography showed ureteral stricture along the ureter with dimension of 1,6 cm and 5 cm distally from orifice. Patient informed consent for ureteric resection and publishing the video of the surgery was obtained. Before surgery, cystoscopy was performed and 4 ml of 0,25% indocyanine green was injected in each ureter 5 cm proximal to orifice. JJ stent was inserted in left ureter. Intraoperatively, severe dense adhesions between uterus, adnexa, sigma and rectum were seen. Adhesiolysis started from left pelvic wall with detachment of the sigma and exposing retroperitoneal structures. Left ovary was mobilized and suspended up to the abdominal wall. Left hydroureter was seen. Its wall was well colored under near-infrared light. Ureterolysis continued distally to the posterior compartment of left parameter where fibrotic tissue of endometriotic lesion affecting the ureter was found. Ureter was mobilized distally to the ureteric channel. During the ureterolysis there was a notable change in the coloring with indocyanine green of the ureteric wall between the healthy and the area affected by endometriosis. After completing the ureterolysis, the endometriotic lesion was very well distinguishable from the intact part when lighted with NIR.

Conclusions

Ureteral indocyanine green enhances defining of endometriotic lesion borders and facilitates the decision for resection lines.

<https://player.vimeo.com/video/1085639520?autoplay=1>

Surgery or Medication for Women with Endometrioma? A Prospective Cohort Study

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Background

Up to now there are no prospective studies that compared surgery and medication for treating ovarian endometrioma, leaving the optimal approach unclear. This study aimed to evaluate the effectiveness of surgery versus medication in improving pain and quality of life for women with endometrioma and pain symptoms.

Methods

This multicentre prospective cohort study included patients with ovarian endometrioma ≥ 3 cm and pain symptoms, i.e. dysmenorrhea, chronic pelvic pain, or dyspareunia, excluding those with deep endometriosis. The primary outcome was $\geq 30\%$ reduction in pain (measured by numeric rating scale (NRS)) at six months for surgery versus medication. Secondary outcomes included quality of life (QoL) (measured by Endometriosis Health Profile Questionnaire (EHP-30)), use of adjuvant medication in the surgery group and surgery in the medication group. Outcomes were assessed using augmented inverse probability weighting.

Results

A total of 224 patients participated with 124 patients included in the surgery group and 100 in the medication group. At baseline, these groups differed regarding a current wish to conceive and maximum/total cyst size. After six months, $\geq 30\%$ pain reduction was achieved in 62% of the medication group versus 76% in the surgery group (OR: 1.91 (95%CI: 1.015-3.573, $P=0.047$). Five domains of QoL scores significantly favored the surgery group over the medication group (P ranging from <0.001 -0.032). Adjuvant hormonal medication use in the surgery group was 76%. Six patients in the surgery group required reintervention and seven in the medication group had surgery. For the primary outcome we performed a sensitivity analysis with propensity score matching which resulted in the same estimate.

Conclusions

Surgery, whether or not combined with adjunctive medication, is more effective than medication alone in reducing pain and improving quality of life associated with endometrioma after six months.

The Double bipolar technique- Novel management of difficult endometriosis cases.

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Background

To introduce the double bipolar technique in the management of severe endometriosis in cases operated with surgical robots.

Methods

Three cases with severe and extensive deep endometriosis will be shown to explain the specific techniques of the double bipolar method. In the double bipolar method, Maryland forceps are used for both cutting and grasping. The small spark between the tips of the Maryland forceps vaporizes target tissue, making dissection safe due to minimizing thermal spread.

Surgeries were performed with the Da Vinci Xi and the single-port Da Vinci SP systems. The Xi was used when performing hysterectomy, DE resection, and low anterior resection for rectal endometriosis. The SP was used in lower anterior resection for rectal endometriosis, and ureteroneocystostomy for ureteral endometriosis. All patients gave their consent for their surgical footage and data to be used for research and educational purposes.

Results

No patients underwent blood transfusion, and the maximum operative time was 2hr 50mins. No thermal injuries or complications occurred. The post-operative courses of all patients were uneventful. Patients could ambulate and take a regular diet the day after surgery.

Conclusions

The double bipolar method can be useful when dealing with difficult endometriosis cases. Both the DaVinci Xi and SP robots can be employed on a case-by-case basis and offer safe dissection and a good cosmetic result for patients.

<https://player.vimeo.com/video/1085302996?autoplay=1>

Restoration of the Rectovaginal Space in Deep Infiltrating Endometriosis (DIE)

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Background

Rectovaginal space endometriosis is a form of deep infiltrating endometriosis (DIE) involving the vaginal, rectal, and the rectovaginal space. It is seen in 3.8% to 37% of patients with endometriosis. Rectovaginal space DIE can present with a triad of symptoms including dysmenorrhea, bowel dysfunction, and dyspareunia. Diagnosis and treatment planning require careful imaging, either with transvaginal ultrasound or MRI, and colonoscopy may also be necessary based on symptoms. While medical management can help alleviate symptoms and reduce lesion size, it does not fully treat DIE. Surgical intervention aims to restore anatomical structures and, in cases of rectal or rectosigmoid involvement, may include procedures such as rectal shaving, discoid resection, or low anterior resection.

In this video, we review a case where the rectovaginal space initially appeared normal but on closer evaluation was found to be obliterated by DIE. The video covers the surgical restoration of this space and provides a brief overview of DIE in the rectovaginal area.

Methods

Conventional laparoscopic evaluation and surgical management of deep infiltrating endometriosis involving the rectovaginal space and rectum.

Results

Successful excision of deep infiltrating endometriosis, restoration of the rectovaginal anatomy, and significant improvement in the patient's symptoms.

Conclusions

Preoperative imaging and meticulous surgical planning are crucial in the management of deep infiltrating endometriosis. A thorough initial examination is essential, as anatomical structures can often appear deceptive. In cases of uncertainty, it is vital to rely on fundamental anatomical knowledge to guide surgical restoration and ensure successful outcomes.

<https://player.vimeo.com/video/1066217955?autoplay=1>

How do endometriomas present in postmenopause? Ultrasound findings, clinical features, and follow-up

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Background

To describe the clinical presentation, ultrasound features, and follow-up outcomes of ovarian endometriomas in postmenopausal women.

Methods

This retrospective, single-center study included postmenopausal patients with ovarian endometriomas who underwent transvaginal ultrasound (TVUS) at the University of Rome Tor Vergata (2017–2025) with ≥ 24 months of follow-up. All had a history of premenopausal endometriosis or prior endometriosis surgery. Clinical and ultrasound assessments were conducted at baseline and at 12, 24, and 36 months, recording changes in US characteristics and symptoms. Endometrioma size was classified using the #Enzian classification.

Results

Among 41 patients (mean age 53 years, mean follow-up 31 months), dyspareunia (18%) was the most common postmenopausal symptom, followed by bowel symptoms (15%). Associated deep infiltrating endometriosis (DIE) was present in 74% of cases. Most had unilateral endometriomas, with only 13% presenting bilateral lesions. The medium diameter of the endometriomas decreased from 19.7 ± 8.0 mm to 15.0 ± 6.8 mm at 12 months. The maximum endometrioma diameter decreased from 21.0 ± 8.9 mm to 17.6 ± 8.5 mm at 12 months ($p = 0.04$), and remained stable thereafter. Most were classified as Enzian O1 (85%) and unchanged over time. Ground-glass echogenicity was present in 90% at baseline, while non-vascularized hyperechoic areas increased from 14% to 22% at 36 months. Two endometriomas disappeared on ultrasound. Symptom severity remained stable.

Conclusions

Endometriomas in postmenopausal patients suitable for follow-up are often small, with most having a history of surgery and associated DIE. Endometriomas often exhibit typical ultrasound features, with a small percentage developing hyperechoic areas over time. TVUS is a valuable tool for monitoring endometrioma characteristics in postmenopausal patients, particularly for detecting potential disease progression in those with severe DIE or a history of multiple surgeries, where a surgical approach may carry a high risk of serious complications.

Silent disease, vast effect: endometriosis associated hydronephrosis, single Endometriosis Centre retrospective study, analysis and pathway.

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Background

Ureteric involvement in endometriosis is uncommon (incidence 0.1-0.4%) and often asymptomatic, but the consequences can be severe, resulting in permanent renal function loss. We present a single centre case series with aim to summarise the findings and pathway in patients with endometriosis associated hydronephrosis.

Methods

Our database search was performed to identify the patients with endometriosis related hydronephrosis between 2009 and 2025 in the single tertiary centre. All patients included in study had unilateral or bilateral hydronephrosis caused exclusively by endometriosis. Demographic characteristics of the patients, laterality and stage of hydronephrosis and treatment pathways were analysed.

Results

67 patient who satisfied the inclusion criteria were identified. Majority of the patients were of White (34%), Black (19%) and Asian (13%) background, with mean age of 32.6, and mean Body Mass Index (BMI) 27.3. Hydronephrosis affected both kidneys in 31% of cases, whilst in the unilateral cases distribution was towards the left side (55%). Urinary symptoms were reported in 29.8%. Hydronephrosis was classified as mild/moderate on imaging in 55% and severe in 45% cases, with complete renal function loss in five patients (three of them had a unilateral nephroureterectomy, one is awaiting procedure, and one opted for conservative management). Regarding the treatment, 90% required procedure: ureteric stent, ureterolysis and/or ureteric re-implantation. Ureterolysis was performed in 29 cases, and 19 patients required ureteric reimplantation. Ureteric stenting was a temporarily procedure in majority of cases (91%), either to relieve the obstruction while they were awaiting surgery (8 patients) and/or fertility treatment completion (4 patients), or as a combined procedure with more complex surgical treatment, such as extensive ureterolysis or ureteric reimplantation. While 84% of people affected chose surgical treatment, 13% decided for expectant management with active monitoring (four of them required ureteric stent placement, whilst surveillance only was suitable in five cases), and 3% were undecided about their treatment as of yet. Conversely, 23 of 67 patients selected definitive surgery, total hysterectomy with bilateral salpingo-oophorectomy and endometriosis excision.

Conclusions

Endometriosis related hydronephrosis represents the challenge for both – diagnosis and management. Symptoms are often non-specific or even absent, whilst the effects can be detrimental. Surgical management, involving complex multidisciplinary team involvement is still the most

common treatment modality. Our data aligns with currently available evidence on mean age at the time of diagnosis, unilaterality and predominantly left side occurrence, whilst the percentage of cases with absent symptoms seems to be significantly higher (70% in our study vs 50% in literature). Clinical vigilance, including active monitoring with high quality imaging (ultrasound, Magnetic Resonance Imaging (MRI), Nuclear Medicine (NM) renogram) is warranted to avoid the silent kidney loss. Early diagnosis and intervention, and multidisciplinary approach within the accredited Endometriosis Centre are the paramount of care in these cases.

Histologic findings from ablation of ovarian endometriomas using argon plasma coagulation (APC): a prospective pilot study.

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Background

Although cystectomy remains the gold standard for ovarian endometrioma surgery, its potential harm to ovarian reserve due to inadvertent removal of ovarian parenchyma has raised concerns. Ablative techniques, like Argon Plasma Coagulation (APC), ensure precision with minimal thermal spread, preserving ovarian reserve. This prospective pilot study aimed to evaluate the thermal damage induced by APC on the endometrioma pseudocapsule in women undergoing surgery for ovarian endometriomas.

Methods

From February 2023 to February 2024, symptomatic women aged >18 years undergoing laparoscopic surgery for ovarian endometriomas were prospectively included for a pilot study in a tertiary university hospital. At the time of surgery, a standard laparoscopic cystectomy or adnexectomy as previously scheduled were performed. APC ablation of a 2x2 cm area on the cyst's inner surface was performed *ex vivo*, with a coagulation mode set at 40-60 W, a distance averaging 5 mm from the tip of the probe and with an exposure time limited to 1-2 seconds on each site. Each histological preparation was examined by the same experienced pathologist. The primary endpoint was histological evaluation of coagulation depth on the pseudocapsule. Secondary endpoints included the extent of damage to adjacent ovarian parenchyma (in adnexectomy cases) and confirmation of complete ablation of endometriotic tissue.

Results

Eleven women were included. Two underwent cystectomy, and nine underwent adnexectomy, both followed by *ex vivo* APC ablation of the endometriomas. The mean coagulation depth was 0.8 ± 0.6 mm and the maximum depth of necrosis at the level of the pseudocapsule of the endometriotic cyst was 1.5 mm. The ablation of endometrial foci was complete: no residual endometrial foci were found in any section of the samples. In all patients who underwent adnexectomy, necrosis induced by APC ablation did not extend beyond the pseudocapsule of the endometriotic cyst to affect the surrounding ovarian parenchyma.

Conclusions

Our study showed that the depth of coagulation using APC is consistently below the 2-3mm of the width of the fibrous cyst wall, totally sparing healthy ovarian parenchyma. Compared to CO₂ vaporization, APC offers a easy and cheaper alternative approach to manage ovarian endometriomas while preserving ovarian reserve. Larger studies are warranted to validate these preliminary results.

The role of perioperative medical therapy on post-surgical clinical outcomes in patients with endometriosis

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Background

Women undergoing surgery for endometriosis are at high risk of symptomatic recurrence over time, and the underlying pathogenetic mechanisms remain poorly understood. One prevailing theory suggests that the perioperative period may create a microenvironment conducive to de novo implantation of endometrial cells through retrograde menstruation. Consequently, avoiding menstruation in the postoperative phase, whether spontaneous or triggered by the temporary suspension of hormonal therapy, could play a key role in preventing recurrence. The objective of this study was to assess the impact of continuing long-term administration of monophasic, low-dose oral contraceptive pills (OCPs) immediately after surgery, compared to suspending treatment for one month postoperatively, in preventing both clinical and anatomical recurrence of endometriosis following conservative surgical treatment.

Methods

This single-center, observational, retrospective cohort study included all patients receiving OCPs who underwent conservative surgical treatment for endometriosis between January 2019 and December 2021 at the Division of Gynecology and Human Reproduction Physiopathology, IRCCS Azienda Ospedaliero-Universitaria of Bologna, Italy. Patients were divided into two groups based on the timing of postoperative resumption of hormonal therapy: the continuous group, who maintained OCP intake starting the day after surgery, and the intermittent group, who resumed treatment at the one-month postoperative follow-up visit. Follow-up visits were conducted periodically for up to 24 months after surgery. The two groups were compared in terms of demographic characteristics and disease localization. The primary outcome was the overall recurrence rate of endometriosis, defined as the presence of symptoms with a Numeric Rating Scale (NRS) score greater than 5 after surgery or ultrasound evidence of recurrent disease. Secondary outcomes included the clinical recurrence rate and the anatomical recurrence rate.

Results

A total of 164 patients were included: 59 (36%) in the continuous group and 105 (64%) in the intermittent group. The two groups were comparable in terms of baseline characteristics, except for a significantly higher prevalence of intestinal disease (57% vs. 82%, $p = 0.001$) and vaginal disease (8.5% vs. 24%, $p = 0.01$) in the intermittent group.

At 24 months, the overall recurrence rate was significantly lower in the continuous group compared to the intermittent group (15% vs. 30%, $p = 0.04$). Kaplan–Meier analysis confirmed a significantly lower cumulative recurrence rate in the continuous group ($p = 0.004$). However, statistical

significance was not reached when evaluating clinical recurrence alone ($p = 0.1$) or anatomical recurrence alone ($p = 0.6$).

Conclusions

Continuation of hormonal therapy immediately after surgery, thereby avoiding the first menstruation postoperatively, appears to reduce the two-year recurrence rate of endometriosis. Further studies with longer follow-up periods are needed to confirm these findings.

Can Elastography Predict the Difficulty of Endometrioma Surgery?

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Background

Endometrioma surgery is crucial due to the difficulty in distinguishing the cyst capsule from surrounding ovarian tissue during excision. Operating at incorrect planes may result in bleeding, inadvertent removal of ovarian tissue, reduced ovarian reserve, or incomplete removal of endometriotic tissue—factors that increase recurrence risk. Therefore, knowledge of the stiffness and elasticity of the endometrioma capsule may help predict cystectomy difficulty preoperatively. This study aimed to assess endometriomas using preoperative elastography before cystectomy and investigate whether elastographic values could predict excision difficulty.

Methods

Twenty-one patients with 22 endometriomas were prospectively enrolled in this pilot study. Capsule stiffness and cyst content density were measured preoperatively using transvaginal shear wave elastography with a 6.5 MHz vaginal probe. Quantitative results were expressed in kilopascals (kPa) or meters per second (m/s).

An experienced laparoscopist, blinded to the elastography findings, performed the excisions. During surgery, the difficulty of capsule excision and the degree of capsular fibrosis were subjectively assessed. Capsules that could be separated from surrounding tissue using traction-contraction with no bleeding except leakage from ovarian tissue were classified as “easily separable.” In contrast, capsules requiring excessive force for removal, fragmenting during separation, and requiring hemostasis were considered “adherent.”

Elastography values of the capsule and cyst content were compared between these two groups. The secondary endpoint was to evaluate whether a correlation existed between endometrioma size and elastography values.

Due to the small sample size, descriptive data were reported as median (IQR) (min–max). Group comparisons were made using the Mann–Whitney test, and correlations were evaluated with the Pearson correlation test. A p-value <0.05 was considered statistically significant.

Results

During 22 endometrioma cystectomies, cyst capsule excision was easy in 13 (59.1%) cases, while it was difficult in 9 (40.9%) cases. The two groups showed no significant differences in age, parity, BMI, CA-125 levels, or cyst size (p>0.05).

The elastography values of the cyst walls were similar in both groups (18.0 (23.2) vs 15.1 (5.0), p=0.276), but the stiffness of the cyst contents was significantly higher in the group with easily

separable capsules (7.0 (4.0) vs 4.5 (3.3), $p=0.047$). There was no significant correlation between the size of the endometrioma and the elastography values of the cyst capsule or contents ($r=0.095$, $p=0.682$; $r=-0.254$, $p=0.120$, respectively).

Conclusions

Preoperative evaluation of capsule stiffness via elastography could not predict the degree of adhesion or surgical difficulty. However, higher elastographic values of cyst contents were associated with easier excision. Denser contents may indicate older endometriomas or be influenced by the menstrual cycle phase. These findings suggest that cyst content stiffness may be a useful predictor for surgical planning, but further studies with larger patient cohorts are needed to confirm these results.

Association Between Endometriosis and Müllerian Anomalies: A Retrospective Study Supporting the Retrograde Menstruation Theory

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Background

To explore the association between endometriosis and obstructive/nonobstructive Müllerian anomalies.

Methods

Patients with Müllerian anomalies (MA) diagnosed and treated at Peking Union Medical College Hospital from January 2003 to December 2024 were recruited. A total of 3,862 MA patients were retrospectively screened, and a total of 1,210 MA patients underwent laparoscopy or laparotomy were included and divided into obstructive Müllerian anomalies (OMA) and nonobstructive Müllerian anomalies (NOMA) group. Relevant clinical data were reviewed retrospectively from medical charts.

Results

OMA patients were diagnosed with MA at a significantly younger age than NOMA patients (17.70 ± 7.52 years vs. 29.86 ± 9.58 years; $P=0.036$). Likewise, the time between diagnosis and surgical intervention was significantly shorter for OMA patients compared to NOMA patients (26.15 ± 47.65 months vs. 34.73 ± 53.20 months; $P=0.045$). Among the 1,210 MA patients, 258 (21.3%) had endometriosis. Endometriosis was significantly more common in OMA patients (170/517, 32.9%) than in NOMA patients (88/693, 12.7%, $P=0.000$). In patients concomitant with endometriosis, the prevalence of ovarian endometrioma was significantly higher in the OMA group compared to the NOMA group (84.7% vs. 71.6%, $P=0.012$). Additionally, the proportion of patients with rASRM stage III-IV endometriosis was significantly higher in the OMA group than in the NOMA group (79.4% vs. 68.2%, $P=0.047$).

Conclusions

This study demonstrates a significant association between OMA and a higher prevalence of endometriosis, particularly ovarian endometriomas, compared to NOMA. These findings reinforce the role of retrograde menstruation in endometriosis pathogenesis and highlight the clinical importance of early diagnosis and intervention in OMA patients to mitigate endometriosis risk.

Targeted hysteroscopic methotrexate injection for caesarean scar pregnancy: insights from a single-center case series

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Background

Caesarean scar pregnancy (CSP) is a rare form of ectopic pregnancy characterized by placental implantation within a previous caesarean section scar. If undiagnosed or improperly managed, CSP may result in uterine rupture and severe hemorrhage. A wide range of treatment modalities exists, yet the lack of high-quality evidence identifying the safest approach places affected women at significant risk of life-threatening complications. This case series aims to describe the surgical and clinical outcomes of patients with CSP treated at our center using a two-step protocol: hysteroscopic-guided methotrexate (MTX) injection into the gestational sac, followed by hysteroscopic removal using a mechanical tissue removal system.

Methods

A monocentric, retrospective analysis of prospectively collected data was conducted between January 2022 and January 2025. Six women diagnosed with CSP underwent hysteroscopic-guided direct MTX injection into the gestational sac.

The procedure was performed under local anesthesia in an outpatient setting using a 2.9-mm Hopkins II Forward-Oblique Telescope 30° endoscope with a 4.3 mm inner sheath and 5F instruments (Karl Storz). A 3.7F Deflux metal needle was introduced into the myometrial tissue at four separate points around the implantation site. Six additional injections were administered directly into the gestational sac, delivering a total of 50 mg of methotrexate.

Serum β -hCG levels were monitored weekly until negativization. After six weeks, avascular trophoblastic remnants identified on ultrasound were removed hysteroscopically using a 6-mm TruClear (Medtronic) tissue removal system.

IRB (institutional review board) approval was obtained from the local ethics committee.

Results

At baseline, five patients presented with an embryo exhibiting cardiac activity, while one case involved only a yolk sac. The mean gestational age was 7 weeks and 2 days; the mean gestational sac diameter was 25 mm; the mean crown–rump length (CRL) was 7.7 mm. All pregnancies were located "in the niche," with a mean residual myometrial thickness of 2.3 mm.

The mean hemoglobin drop post-procedure was 1.1 g/dL. Mean β -hCG decline was 41.3% at 4 days and 99.4% at 4 weeks.

Five patients underwent hysteroscopic removal of residual tissue, while one experienced complete spontaneous expulsion after MTX injection.

The mean hospital stay was 2 days. Uterine integrity was preserved in all cases. One patient subsequently achieved a successful pregnancy.

Conclusions

In this case series, hysteroscopic MTX injection followed by hysteroscopic removal of CSP remnants proved to be a safe and effective approach. The method was minimally invasive, associated with short hospitalization, and resulted in no major complications. Moreover, it enabled high local drug concentrations while minimizing the risk of intra- and post-operative bleeding. Further studies with larger cohorts are required to assess long-term fertility and pregnancy outcomes.

Ultrasound-guided mechanical hysteroscopic resection of a cesarean scar ectopic pregnancy: a conservative and effective approach

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Background

Cesarean scar ectopic pregnancy is a rare but potentially life-threatening condition that requires timely diagnosis and careful management. Minimally invasive approaches, particularly hysteroscopic techniques, have shown promising results in selected cases. This video presents a step-by-step demonstration of ultrasound-guided hysteroscopic resection of a cesarean scar ectopic pregnancy, emphasizing a conservative and fertility-preserving technique.

Methods

A 33-year-old patient (G4P1A2) presented with six weeks of amenorrhea, pelvic pain, and vaginal bleeding. Transvaginal ultrasound confirmed a viable cesarean scar pregnancy, with an overlying myometrial thickness of 4 millimeters. After failed inpatient medical management with systemic methotrexate, hysteroscopic resection was performed under transrectal ultrasound guidance using a Gubbini mini-resectoscope. In the isthmic region, a large isthmocoele containing the gestational sac was identified. No other lesions were observed in the cervical canal or uterine cavity. The sac was excised mechanically, using the resectoscope loop without energy activation to carefully separate it from its implantation site, thereby minimizing the risk of uterine perforation. Hemostasis was achieved using minimal bipolar coagulation. The specimen was collected and sent for histopathological analysis. A post-procedure transvaginal ultrasound confirmed complete removal of the gestational sac.

Results

The procedure was well tolerated, and the patient was discharged the following day. Histology confirmed the presence of chorionic villi consistent with early pregnancy tissue. No complications were reported during follow-up.

Conclusions

This video highlights a conservative and effective technique for the management of cesarean scar ectopic pregnancy. Ultrasound-guided hysteroscopic excision using a non-energized resection loop offers a safe, accurate, and fertility-sparing treatment option.

<https://player.vimeo.com/video/1085469739?autoplay=1>

A Cornu-Saving Medial Laparoscopic Approach for Cornual Ectopic Pregnancy

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Background

This case report presents the surgical management of a cornual ectopic pregnancy using a uterine cornu-preserving medial laparoscopic approach. It aims to emphasize the safety and efficacy of minimally invasive, fertility-sparing surgery that preserves both the uterine cornu and fallopian tube in selected cases of cornual ectopic pregnancy.

Methods

A 21-year-old patient, with a gestational age of 11 weeks based on her last menstrual period, was admitted to the Department of Obstetrics and Gynecology, Bursa Uludağ University, with a diagnosis of cornual ectopic pregnancy. Transvaginal ultrasonography revealed a live embryo measuring 10+5 weeks by CRL, located in the right cornual region.

Following a cornu preserving medial incision over the uterine cornu and fallopian tube, the endometrium was incised and the gestational material was completely excised. After confirming the absence of residual tissue, the endometrial cavity was closed with a single layer of 2-0 polyglactin suture. The myometrial layer was approximated using a single layer of barbed suture, and a second layer including the uterine serosa was applied to complete the repair. The excised tissues were retrieved using an endobag. The patient was discharged on postoperative day one without complications.

Results

Fertility-preserving laparoscopic surgery was successfully performed. Postoperative evaluation confirmed the integrity of the uterine cornu and fallopian tube. On postoperative day seven, transvaginal ultrasonography revealed preserved cornual anatomy.

Conclusions

Cornual ectopic pregnancy is a potentially life-threatening condition requiring prompt surgical intervention. As demonstrated, the medial laparoscopic approach offers safe, effective management with minimal blood loss, rapid recovery, and fertility preservation.

<https://player.vimeo.com/video/1085459882?autoplay=1>

Ovarian teratoma associated anti -nmda receptor encephalitis: a surgical approach to a neurological emergency

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Background

Anti-NMDA receptor encephalitis is a rare autoimmune disorder often affecting young women and associated with ovarian teratomas. Early identification and removal of the underlying tumor can significantly improve neurological outcomes. This case highlights the multidisciplinary management of a patient with neuropsychiatric symptoms secondary to a mature cystic teratoma.

Methods

A 28-year-old woman presented with acute agitation, auditory hallucinations, and confusion. CSF analysis revealed elevated protein levels and was positive for anti-NMDA receptor antibodies. Pelvic imaging demonstrated a 4 cm dermoid cyst in the right ovary. The patient underwent laparoscopic ovarian cystectomy under general anesthesia. Standard trocar placement was performed. The cyst was dissected from ovarian tissue using a dissector, its contents were aspirated, and the specimen was removed via an Endobag. Intraoperative frozen section confirmed the diagnosis of mature cystic teratoma.

Results

The contralateral ovary appeared normal. Hemostasis was achieved with bipolar cautery. Postoperative recovery was uneventful. The patient continued treatment with corticosteroids and plasmapheresis. Gradual improvement in neuropsychiatric symptoms was observed during the inpatient follow-up. The patient tolerated both surgical and immunosuppressive therapy well, and no postoperative complications were noted.

Conclusions

This case emphasizes the importance of evaluating paraneoplastic etiologies in young women with acute neuropsychiatric symptoms. Early gynecological intervention, alongside immunotherapy, can lead to favorable outcomes. Multidisciplinary collaboration was essential in achieving an accurate diagnosis and effective treatment.

<https://player.vimeo.com/video/1085344045?autoplay=1>

Laparoscopic Management of a Ruptured 16-Week Interstitial Pregnancy: A Complex Surgical Case.

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Background

To demonstrate the feasibility and effectiveness of laparoscopic management in a haemodynamically stable patient with a ruptured second-trimester interstitial (cornual) pregnancy, and to highlight the diagnostic and intraoperative challenges associated with this rare presentation.

Methods

We present the case of a 35-year-old P1 woman with a background of previous caesarean section (2023), PCOS, chronic pain syndrome, fibromyalgia, and depression. She presented with non-specific symptoms including headache, vomiting, and reduced oral intake. Initial bedside assessment during her hospital visit a week before presentation and booking scan at 12 weeks reported a viable intrauterine pregnancy; however, subsequent imaging on presentation revealed a non-viable fetus in the right adnexa and a vascular placental mass, along with moderate hemoperitoneum. Haemoglobin was 53 g/L, requiring urgent transfusion. Laparoscopy was performed and revealed a ruptured right interstitial pregnancy with placental extrusion into the peritoneal cavity.

Results

Surgical management included laparoscopic right segmental uterine resection, right salpingectomy, adhesiolysis, uterine reconstruction, and in-bag morcellation of the placenta; the fetus was removed intact through a 12mm port. Estimated blood loss was 500 ml. Post-operatively, the patient experienced vomiting and was found to have suspected ileus on CT. Conservative management was adopted, and the patient recovered without further intervention, being discharged on the fifth day post-operation.

Conclusions

This case highlights the diagnostic complexity of second-trimester interstitial pregnancies and the importance of maintaining high clinical suspicion despite reassuring early imaging. It illustrates that in carefully selected stable patients, laparoscopic surgery is a safe and effective option for managing ruptured interstitial pregnancies, even in the second trimester. The accompanying video demonstrates key surgical steps and considerations in managing this rare but life-threatening condition.

<https://player.vimeo.com/video/1083817704?autoplay=1>

Minimally Invasive suRGery in recurrent Endometrial cancer (MIRaGE)

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Background

Minimally invasive surgery (MIS) is increasingly utilized for primary endometrial cancer (EC) due to its documented safety and efficacy. However, its application in secondary cytoreductive surgery (SCS) for recurrent EC is underexplored, and comparative data on its feasibility, safety, and oncologic outcomes remain limited. This study aimed to identify predictive factors for the feasibility of minimally invasive SCS, defined as complete gross resection. Secondary objectives were to compare intraoperative, perioperative, and survival outcomes between MIS and open surgery.

Methods

This retrospective multicentre study included patients with first abdominal recurrence of EC who underwent SCS from January 2010 to December 2023 across three Italian centres. Patients were categorized by surgical approach (MIS or open surgery), and data were analysed to identify predictive factors for MIS feasibility and to compare perioperative and survival outcomes between groups.

Results

Among 192 patients, 74 (38.6%) underwent MIS, while 118 (61.5%) received open surgery. MIS was associated with lower blood loss (100mL vs 200mL, $p < 0.001$), fewer intraoperative transfusions (6.8% vs 17.8%, $p=0.030$), and shorter operative times (180 vs 250 minutes, $p<0.001$). Predictive factors for MIS feasibility included BMI ≥ 30 (OR:2.193, $p=0.026$), early-stage disease (OR:3.426, $p=0.004$), single-site relapse (OR:2.850, $p=0.029$), and specific recurrence patterns (loco-regional and lymph-node recurrence, OR:5.100 $p=0.018$ and OR:4.346, $p=0.038$). Survival outcomes, including Post-Relapse Free Survival (PRFS) and Post-Relapse Survival (PRS), were comparable between groups ($p=0.355$ and $p=0.466$ respectively) (Table 1).

Variables	OR (95% CI)	p-value
BMI ≥ 30 Kg/m ²	2.193 (1.096-4.385)	0.026
early stage FIGO (2009)	3.426 (1.478 – 7.940)	0.004
single-site relapse	2.850 (1.115-7.286)	0.029
loco-regional relapse	5.100 (1.322-19.680)	0.018
lymph-node relapse	4.346 (1.085-17.401)	0.038

Table 1 Predictive factors for MIS feasibility

Conclusions

MIS is feasible and effective for SCS in selected patients with recurrent EC, achieving high rates of complete resection. Predictive factors for MIS feasibility include BMI ≥ 30 , early-stage disease, single-site relapse, and specific recurrence patterns (loco-regional and lymph-node recurrence). When feasible, MIS is associated with reduced perioperative morbidity, including lower blood loss, fewer transfusions, shorter operative times, and reduced hospital stays, without compromising oncologic outcomes. Comparable PRFS and PRS between MIS and open surgery support MIS as a safe and effective alternative in patients with favourable clinical profiles.

Transumbilical Single-Incision Laparoscopic Retroperitoneal Tumor Resection

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Background

The patient is a 35-year-old woman, G2P2, with a history of two caesarean sections. Ultrasound examination revealed cystic masses in the bilateral adnexal regions, and MRI suggested a suspected retroperitoneal tumor with a predominantly cystic structure (7 cm × 5 cm × 5 cm on the left side, 4 cm × 3 cm × 3 cm on the right side). The patient had no subjective discomfort. For further diagnosis and treatment, she requested trans umbilical single-incision laparoscopic surgery.

Methods

A single-port laparoscopic surgical platform was established via the trans umbilical approach. After the pelvic cavity for exploration, a significant bulging appearance was observed in the retroperitoneum beneath the bilateral iliac vessels. Palpation with laparoscopic instruments confirmed the presence of retroperitoneal tumours.

The surgery involves addressing the following key challenges:

1. **Difficult exposure:** The retroperitoneal tumor is in the posterior pelvis, requiring an individualized suspension technique to overcome the exposure challenge.
2. **High demands on the surgeon:** Performing retroperitoneal tumor surgery with a single-port laparoscopic approach places significant demands on the primary surgeon operating alone.
3. **Identification of critical anatomical structures:** It is essential to recognize important retroperitoneal anatomical structures to prevent injury to major blood vessels and nerves.

Results

Due to the tumor being in the posterior pelvis, exposure was challenging. An individualized suspension technique was employed intraoperatively, effectively addressing the issue of limited visibility. The surgical procedure proceeded smoothly, with the primary surgeon performing precise manoeuvres under single-port conditions, successfully dissecting, and completely resecting the tumor. Critical anatomical structures were carefully identified during the operation to avoid damage to major blood vessels and nerves. The bilateral tumours were confirmed as schwannomas, with an estimated blood loss of approximately 50 ml and no significant complications observed.

Conclusions

Postoperatively, the patient developed left lower limb pain and dorsiflexion weakness, while sensation and motor function remained unaffected in the right. The final diagnosis confirmed the retroperitoneal tumor as a schwannoma. Due to its higher position on the left, involving the lumbosacral nerve trunk, the patient experienced related motor and sensory complications. This case serves as a reminder for gynaecologic surgeons to exercise caution when managing retroperitoneal tumours and to call for collaboration to reduce damage.

<https://player.vimeo.com/video/1065473365?autoplay=1>

Robotic approach for lymph nodal recurrence in ovarian cancer: lymphatic anatomy, vascular damage control, no-touch en-bloc resection.

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Background

Selected patients with single or oligometastatic lymph nodal recurrence of ovarian cancer can potentially benefit from minimally invasive secondary cytoreductive surgery, which provides favourable perioperative outcomes, reduce blood loss and shorter hospital stays, without compromising survival, compared to open approaches in retrospective series. In this context robotic surgery offers additional advantages in terms of dexterity of movements, tremor filtering, enhanced visualization, ergonomic positioning and ultrasound integration via tilepro setting, making it highly effective in managing gynecological cancers recurrences. This video presents a robotic approach for complex oligometastatic ovarian cancer recurrence, integrating selective vascular and lymphatic control and no touch en-bloc resection technique.

Methods

A 61-year-old women with a good performance status and BMI 20.3 kg/m², presented with third platinum-sensitive lymph nodal recurrence of high grade serous ovarian cancer BRAC1mut. She had previously undergone interval debulking surgery with HIPEC (RT=0) followed by adjuvant platinum-based chemotherapy, PARP inhibitor maintenance, and radiotherapy for a prior single lymph node recurrence. The CT imaging revealed oligometastatic pelvic and para-aortic inframesenteric recurrence without ascites (Ca125 serum level of 450 U/mL). Following multidisciplinary evaluation, secondary cytoreductive surgery (RT=0) was performed using the Da Vinci Xi System (Intuitive Surgical, Sunnyvale, CA). Surgical steps included:

1 Deep and superficial lymphatic pathways selective control: Selective distal and proximal control of common, external and internal iliac vessels and related deep and superficial lymphatic pathways were achieved. Critical neurovascular structures were isolated from metastatic lymph nodes to establish clear operative fields, minimize bleeding and nervous system injury. The selective identification of lymphatic pathways can facilitate targeted sealing or clipping, potentially reducing lymphatic morbidity.

2 Vascular damage control: An intraoperative lesion of the external iliac vein was managed using vessel clipping and robotic suturing, achieving bleeding control and preventing hemodynamic instability without conversion to open surgery.

3 En bloc resection with no-touch isolation technique: Lymph node packages were removed en-bloc using gentle traction on surrounding tissue, without direct manipulation of metastatic nodes, reducing tumor cell spillage risk.

Results

The operative time was 240 min with estimated blood loss of 300 ml. The post-operative hospital stay was 5 days, with no complications within 30 days.

Conclusions

This robotic approach combining anatomical dissection of lymphatics and vessels, vascular damage control and en-bloc resection is feasible and reproducible for oligometastatic lymph node recurrence treatment. This approach represents a technically safe strategy for managing complex recurrences, enabling precise and complete dissection with negative margins. It minimizes lymphatic-related morbidity through selective clipping of lymphatic channels, mitigates the risk of vascular complications by securing early vascular control and applying effective vascular management strategies, and maximizes oncological safety by aiming to prevent intraoperative tumor rupture and spillage.

<https://player.vimeo.com/video/1091454657?autoplay=1>

Guaze-blocking: A laparoscopic technique for para-aortic lymphadenectomy

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Background

Laparoscopic systematic para-aortic lymphadenectomy is a demanding technique. Here we demonstrate a safe and feasible laparoscopic method for para-aortic lymphadenectomy, involving a guaze-block technique of the intestines and ureters.

Methods

Systematic para-aortic lymphadenectomy was performed under laparoscopic guidance. The patient was a 54-year-old G5P3 woman who was found an intrauterine lesion with the size of more than 2cm, and given the preliminary diagnosis of endometrial cancer. Firstly, the peritoneum was incised and lifted to expose the abdominal aorta (AA) and inferior vena cava (IVC). Here we used two guazes to block the intestines and ureters. The lymph nodes on the anterior, lateral, and posterior surface of the aforementioned vessels were removed as routine by a harmonic scalpel. This technique allowed the para-aortic lymph nodes to be resected safely and efficiently.

Results

The total operative time was about 200 min and the estimated blood loss was 50 ml. The histopathologic findings were G1 differentiated adenocarcinoma with shallow myometrial invasion (Stage IA2).

Conclusions

We successfully performed laparoscopic systematic lymphadenectomy around the AA and IVC. Our surgical technique involving a novel guaze-block method may allow para-aortic lymph nodes to be safely resected with lower risk and less technical difficulty.

<https://player.vimeo.com/video/1090783666?autoplay=1>

Minimally Invasive Approach in Vulvar Cancer: Video Endoscopic Inguinal Lymphadenectomy (VEIL)

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Background

Vulvar cancer accounts for 3–5% of all gynaecologic malignancies and is the fourth most common gynaecologic cancer. The average age at diagnosis is around 70 years. This video abstract presents the surgical treatment and adjuvant management of a patient diagnosed with locally advanced vulvar cancer.

Methods

A 73-year-old female patient presented with a necrotic mass of approximately 5 cm involving both labia and the clitoris. A vulvar biopsy revealed HPV-unrelated, keratinized-type squamous cell carcinoma. PET-CT showed a bilateral vulvar lesion, extending posteriorly on the left and reaching the vaginal orifice, measuring approximately 38×69 mm, located in the skin and subcutaneous tissue, with an exophytic component and pathological FDG uptake (SUVmax: 12.60). Additionally, a lymph node measuring approximately 13×10 mm with pathological FDG uptake (SUVmax: 3.55) was observed in the right inguinal region. The patient underwent total vulvectomy and bilateral video endoscopic inguinal lymphadenectomy (VEIL). The VEIL portion of the surgical procedure is demonstrated in detail in the accompanying video.

Results

Histopathological evaluation revealed a 10.5×9.5 cm unifocal, well-differentiated squamous cell carcinoma with a depth of invasion of 17 mm and lymphovascular space invasion. Epithelial dysplasia was observed at the surgical margins. Two positive lymph nodes were detected on the right side, with a minimum tumor-free margin of 3 mm. Due to high-risk pathological features, the patient was discussed in a gynaecologic oncology tumor board and referred for adjuvant chemoradiotherapy.

Conclusions

VEIL is a safe and effective minimally invasive approach in vulvar cancer surgery. Careful patient selection and surgical expertise are essential for optimal outcomes.

<https://player.vimeo.com/video/1090074809?autoplay=1>

Transumbilical laparoscopic single-site extraperitoneal approach for pelvic and para-aortic lymphadenectomy for staging of endometrial carcinoma

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Background

To present a trans umbilical laparoendoscopic single-site (TU-LESS) extraperitoneal approach for lymphadenectomy in a patient with advanced endometrial carcinoma.

Methods

A 55-year-old woman who diagnosed as high-grade endometrial carcinoma, FIGO stage IIc (2023) /T1a0N0M0, was performed by the TU-LESS TH/BSO, extraperitoneal pelvic lymphadenectomy and para-aortic lymphadenectomy.

Results

Para-aortic and obturator lymphadenectomy through the TU-LESS extraperitoneal approach was successfully performed without complications. The patient recovered quickly and remains alive without recurrent.

Conclusions

It is feasible to perform systematic lymphadenectomy with the TU-LESS extraperitoneal approach.

<https://player.vimeo.com/video/1085761297?autoplay=1>

Impact of peritoneal vaginoplasty combined with radical hysterectomy on the quality of sexual life for patients with early-stage cervical cancer

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Background

Radical hysterectomy (RH) is commonly used to treat early-stage cervical cancer in women of childbearing age and sexual dysfunction due to postoperative vaginal shortening is a major concern. The impact of intraoperative vaginoplasty on prognosis and quality of sexual life in patients with early-stage cervical cancer remains controversial and lacks high-level evidence. However, there are few reports on vaginoplasty after RH to lengthen vagina in patients. This prospective, multi-centric, randomized controlled trial aims to explore the impact of peritoneal vaginoplasty with or without ovarian transposition after laparoscopic RH on sexual dysfunction in patients with early-stage cervical cancer.

Methods

Eligible patients will be randomly assigned (1:1) to receive peritoneal vaginoplasty or not. The sexual life of post hysterectomy patients and general women were also included in this study as control groups with 184 each. The primary evaluation indicators are female sexual function index (FSFI) and male sexual satisfaction scale(MSSS). The secondary evaluation indicators include EORTC QLQ-CX24, 2-year overall survival (OS), 5-year OS, 2-year progression-free survival (PFS), 5-year PFS and surgery-related complications.

Results

431 patients had been included in the research, of which 193 were vaginal lengthening and 238 were non-vaginal lengthening. We collected 443 EORTC QLQ-CX24, including 128 vaginal lengthening and 315 non-vaginal lengthening. The mean and standard deviation of FSFI in patients with vaginal lengthening, non-vaginal lengthening, post hysterectomy and general women were 60.062 ± 11.727 , 32.457 ± 10.757 , 62.984 ± 5.877 and 73.788 ± 7.950 . Patients with vaginal lengthening had significantly higher FSFI (95% CI 0.881-0.967, $p < 0.01$) than non-vaginal lengthening. However, FSFI (95% CI 0.818-0.920, $p < 0.01$) were lower in vaginal lengthening patients compared to general women. Accordingly, the mean and standard deviation of MSSS in patients with vaginal lengthening, non-vaginal lengthening, post hysterectomy and general women were 77.891 ± 12.719 , 45.267 ± 19.712 , 80.957 ± 10.219 and 92.777 ± 10.508 . Similarly, MSSS of patients with vaginal lengthening was superior to non-vaginal lengthening (95% CI 0.869-0.942, $p < 0.01$) while lower than that of general population (95% CI 0.767-0.88, $p < 0.01$). There were no significant difference in FSFI (95% CI 0.375-0.559, $p = 0.875$) and MSSS (95% CI 0.337-0.516, $p = 0.154$) between patients with post hysterectomy and vaginal lengthening.

Conclusions

Peritoneal vaginoplasty can significantly improve the postoperative sexual life of patients with cervical cancer, while the quality of sexual life is slightly lower than that of general women.

"Not Just a Tubo-Ovarian Abscess" A Case Report of a Low-Grade Appendiceal Mucinous Neoplasm

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Background

Key words: Tubo-ovarian abscess, Adnexal mass, Pelvic inflammatory disease

Tubo-ovarian abscesses (TOAs), typically linked to pelvic inflammatory disease (PID), requires timely medical or surgical intervention to prevent morbidity. However, rare neoplasms like low-grade appendiceal mucinous neoplasms (LAMN,) often diagnosed postoperatively, can mimic TOAs, complicating management. This case illustrates the diagnostic ambiguity between infectious and neoplastic aetiologies and reinforces the need for histopathological evaluation in persistent cases.

Methods

Case Summary

A 38-year-old nulligravida presented with right iliac fossa pain in October 2024. She reported no PID risk factors (e.g. recent STI exposure, intrauterine device use). Initial imaging revealed a 9.5 cm right adnexal mass consistent with a TOA.

There was initial clinical improvement and radiologically the TOA reduced to 4cm. The patient underwent extensive outpatient antibiotic therapy. In February 2025, the patient described a return of pain and had radiological persistence of the TOA. She was booked for laparoscopic drainage, excision of the TOA and bilateral salpingectomy.

Results

Laparoscopy revealed

- · Dense adhesions obscuring the appendix.
- · Bilateral pyosalpinx and TOA adherent to the posterior uterine wall.
- · Ovaries adherent to the uterus and bowel.

Techniques Employed:

- · Hydro-dissection and sharp adhesiolysis to restore anatomy.
- · Bilateral salpingectomy and TOA excision (patient declined fertility preservation).

The histology confirmed the right fallopian tube and TOA capsule demonstrated mucinous epithelium with low-grade cytologic atypia, confirming LAMN.

Conclusions

This case underscores the importance of surgical exploration in persistent TOAs and expands the differential diagnosis to include rare neoplasms like LAMN. Histopathological confirmation remains pivotal in guiding management.

Learning Points

- · Consider neoplastic etiologies in TOAs without classic PID features.
- · Multidisciplinary collaboration (radiology, surgery, pathology) is critical for complex pelvic masses.

<https://player.vimeo.com/video/1084711065?autoplay=1>

Gyn-Twin study: 3D Digital Twin for Precision Surgery in Gynecological Neoplasms

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Background

In an era of rapid innovations, the development of advanced technologies is revolutionizing Healthcare, providing physicians and surgeons with more precise tools for diagnostics and interventions.

Particularly in the field of gynaecologic oncology surgery, large tumours can compress or infiltrate surrounding organs, hindering understanding detailed relationships on two-dimensional images and paving the way for 3D Reconstruction models to address these challenges.

The aim of this study is to demonstrate that creation of 3D-digital twin can improve the management of patients affected by gynecological tumours, from anatomical understanding to the surgical planning up to intraoperative navigation and training.

Methods

The first pilot case of the study enrolled a 46 years old patient with a recent diagnosis of vaginal high-grade adenocarcinoma with mesonephric-like differentiation. Preoperative CTscan and pelvic-MRI showed a 3cm lesion involving the right postero-lateral vaginal fornix.

To plan the surgery, the segmentation of the 3D models from preoperative CTscan was achieved using 3D-Slicer image computing software.

Results

The surgery consisted in laparoscopic radical hysterectomy type C1 on the left and C2 on the right, en bloc removal of the upper two-thirds of the vagina with the right parametria and paracolpium, bilateral adnexectomy, recto-sigmoid resection, pelvic lymphadenectomy with vaginally assisted minimally invasive manchette, end-to-end colorectal anastomosis and protective ileostomy.

Estimated blood losses were about 100ml and the operative time was 320min.

Conclusions

The three-dimensional reconstruction of the lesion allowed for appropriate preoperative planning, leading to en-bloc resection of the disease with free margins.

In gynaecologic oncology, surgical digitalization through 3Dtechnologies and its application have the potential to enhance the quality, safety, and efficacy of the preoperative planning and intraoperative navigation enriching the way surgery is performed and conceptualized.

<https://player.vimeo.com/video/1086457936?autoplay=1>

Three-Step Approach to Common Iliac and Para-Aortic Nodal Recurrence in Endometrial Cancer: Vascular Control, Ultrasound-Guided Mapping, and No-Touch En-Bloc Resection

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Background

In obese patients with nodal recurrence of endometrial cancer, surgical resection presents unique anatomical and technical challenges, especially in the context of complex anatomical areas or previously irradiated fields. This study presents a strategic, safe, and effective three-step robotic approach aimed at improving oncologic outcomes while minimizing intraoperative complications in such difficult cases. The technique integrates vascular control, image-guided precision, and no-touch en-bloc principles to ensure radical and safe lymphadenectomy in patients with unfavourable surgical conditions.

Methods

A standardized three-step surgical technique was applied in selected obese patients with common iliac and para-aortic nodal recurrence of endometrial cancer:

Step 1 – Vascular Control: Selective distal and proximal control of both arterial and venous vessels, including the common and external iliac arteries and veins, was achieved. Critical neurovascular structures were isolated and dissected free from the metastatic lymph nodes to establish a clear operative field and minimize intraoperative bleeding.

Step 2 – Ultrasound-Guided Precision Mapping: Intraoperative ultrasound was utilized to delineate cranial and caudal margins of dissection, identify vascular boundaries such as the renal artery, and enhance anatomical orientation. This real-time guidance allowed for precision-tailored resection in patients with altered anatomy due to obesity or prior treatments.

Step 3 – No-Touch En-Bloc Resection: The lymph node package was removed en bloc using gentle traction and pressure on surrounding tissue, without direct manipulation of the metastatic nodes. This no-touch technique aims to reduce the risk of tumor cell spillage and preserve oncologic safety.

Results

This three-step approach was feasible and reproducible in obese patients with nodal recurrence. It facilitated complete resection with clear margins, excellent vascular control, and minimal intraoperative complications. No major vascular or nerve injuries occurred, and no cases of intraoperative tumor rupture or dissemination were observed.

Conclusions

The described three-step technique provides a rational, oncologically adequate, and technically safe strategy for managing nodal recurrences in obese endometrial cancer patients, especially in

anatomically complex or previously irradiated fields. This robotic approach combines safety, efficacy, and precision, offering a valuable tool for surgeons managing high-risk, challenging cases.

<https://player.vimeo.com/video/1091410214?autoplay=1>

Navigating Through Bladder Endometriosis: a Combined Cystoscopic and Laparoscopic Approach

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Background

Bladder endometriosis, the most common form of urinary tract endometriosis, is a rare manifestation accounting for less than 1% of all endometriosis cases. Its nonspecific symptoms often pose a diagnostic challenge, highlighting the importance of clinical awareness.

Methods

Video presentation of a surgical clinical case. The patient gave informed consent to present her personal data.

Results

We present a case and surgical video of a 32-year-old nulliparous, otherwise healthy woman with a 3-year history of sudden onset, non-cyclic haematuria, suprapubic pain, and dysuria. Pelvic MRI revealed a deeply infiltrating endometriotic nodule measuring 42 mm, involving the posterior bladder wall, obliterating the vesicouterine recess, and infiltrating the anterior uterine wall. The patient underwent surgery, combining diagnostic cystoscopy and laparoscopic partial bladder cystectomy. During cystoscopy, the lesions were clearly identified and mapped to facilitate their excision during the subsequent laparoscopic stage. Thereafter, in the laparoscopic approach, the peritoneum of the vesicouterine reflection was opened, and dissection of the obliterated vesicouterine space was performed to expose the posterior bladder wall. A partial cystectomy of the posterior bladder wall was then carried out using a monopolar hook. Bladder closure was performed in two layers using Vicryl® 3/0 for the mucosal and muscular layers, followed by Vicryl® 2/0 for the serosal layer. Bladder integrity was confirmed with a methylene blue test at the end of the procedure. The surgery was uneventful, and the patient remains under follow-up with improvement in symptoms.

Conclusions

When medical therapy fails, surgical excision provides effective symptom relief with low recurrence rates of bladder endometriosis lesions. This case report illustrates how combined laparoscopic and cystoscopic approaches can be successfully performed by a highly skilled gynaecologist. A thorough understanding of pelvic anatomy and surgical expertise, with multidisciplinary support available when needed, are essential for the optimal management of these patients.

<https://player.vimeo.com/video/1090222788?autoplay=1>

Acute Admissions in Endometriosis: Patterns, Risk-factors, and management at a Tertiary Gynaecological Centre

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Background

Acute exacerbations of endometriosis present significant clinical and resource-related challenges. A clearer understanding of the underlying clinical patterns, patient-specific risk factors and management approaches is essential to optimise clinical management, service planning and develop preventative strategies.

Methods

A retrospective observational study was conducted on all acute admissions with a diagnosis of endometriosis between May 2024 and May 2025 at a tertiary referral centre. Clinical data were extracted from electronic records, including demographics, presenting symptoms, prior hormonal and/or fertility treatments, menstrual cycle phase, duration of hospital stay and type of management. Descriptive methodology was applied to analyse the admission characteristics and management trends.

Results

A total of sixty-eight acute admissions were identified with a repeat admission rate of 23.5%. The mean age was 33.1 years (median 33.5, range 17–56), and the mean BMI was 24.5 kg/m² (median 24, range 16.2–35). Conservative management was most common (50%), followed by medical (29.4%) and surgical treatment (20.6%). The average hospital stay was 3.4 days.

Primary indications for admission were exacerbation of endometriosis-related pain (63.2%) and infected endometriomas (22.1%). Among pain exacerbation cases, 79.1% were managed conservatively, including analgesia and supportive care; 14% were initiated on hormonal suppressive therapy and 4.7% underwent surgery. Infected endometriomas were managed with intravenous antibiotics in 66.7% of cases, whereas 20% required surgical intervention. Surgical procedures for infected endometriomas included drainage and washout (33.3%), laparoscopy with adhesiolysis and drainage (16.7%), robotic assisted drainage (16.7%), and complex laparotomy procedures involving adhesiolysis, salpingectomy, and drainage via laparotomy (16.7%). All endometrioma ruptures required surgical management (100%).

A higher mean BMI (27 kg/m²) was observed in patients admitted with infected endometriomas. Ethnic distribution varied by admission cause, with the highest representation of Asian ethnicity (40%) in infected endometrioma cases. Prior hormonal therapy was absent in 47% of total admissions, whereas Dienogest and LNG-containing Mirena IUD were the most frequently used hormonal treatments among those with pain exacerbations. Only 5.9% had recent fertility treatment, though ovulation induction or oocyte retrieval was associated with a higher rate of infected endometriomas.

Admission timing correlated with menstrual cycle phases: pain exacerbations most often occurring during menstrual (17.1%) and/or the follicular phase (11.4%), while infected endometriomas were more likely to present mid-cycle (33.3%) or during unknown menstrual phases (66.7%).

Conclusions

This analysis highlights key associations between clinical presentations of acute endometriosis admissions, management strategies, and patient-specific factors, including BMI, ethnicity, hormonal treatments, fertility interventions, and menstrual cycle phases. These findings provide valuable insights to support improved risk stratification, patient counselling and to develop targeted preventive and management strategies in acute endometriosis care.

Robotic Management of an Occult Rectovaginal Fistula Following Radical Surgery for Deep Infiltrating Endometriosis – A Surgical Video Report

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Background

Rectovaginal fistulas (RVF) are rare but serious complications after surgical treatment of deep infiltrating endometriosis (DIE). This case highlights the diagnostic challenges and surgical strategies for managing an occult RVF.

Methods

A 37-year-old woman with symptomatic DIE and completed family planning underwent robotic-assisted total laparoscopic hysterectomy, bilateral salpingectomy, and excision of endometriotic lesions, including peritoneal stripping and rectal shaving. Intraoperative perfusion assessment was performed using indocyanine green (ICG). Five weeks postoperatively, the patient developed a symptomatic hematoma in the pouch of Douglas, which was managed laparoscopically. Several weeks later, she reported vaginal passage of air and stool, raising suspicion of a rectovaginal fistula (RVF). Initial endoscopic evaluations failed to detect a fistulous tract. Only the combination of endoscopy and bimanual vaginal palpation revealed a small RVF. An over-the-scope clip (OTSC) was applied endoscopically, providing only temporary symptom relief. Due to persistent symptoms, a robotic-assisted laparoscopic fistulectomy, was performed with ICG guidance for the fistula detection.

Results

The video demonstrates the key steps of a robotic fistulectomy: adhesiolysis, precise excision of the fistula with rectally administered ICG to localize the fistula. Additionally, a peritoneal patch and an omental flap were applied to ensure adequate separation and healing between rectum and vagina. The procedure was completed without intraoperative complications. The patient was discharged on day three without any postoperative complications and recovered uneventfully.

Conclusions

RVF represent a rare but challenging complication of extensive endometriosis surgery. Robotic-assisted laparoscopic surgery offers superior visualization and precision in the deep pelvis, enabling safe and effective management of complex fistulas. The use of ICG can help to identify the fistula. This video serves as a technical guide and demonstrates the advantages of a minimally invasive, tissue-sparing approach in the treatment of RVF.

<https://player.vimeo.com/video/1085791668?autoplay=1>

long-term outcomes of different urethropexy techniques using synthetic materials for stress urinary incontinence treatment in women: a 20-year retrospective-prospective analysis (preliminary results).

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Background

Relevance: stress urinary incontinence affects 5–69% of women, leading to social maladjustment, depressive disorders, and sexual dysfunction. Despite the high short-term efficacy of urethropexy (96.1% at 1 year), long-term outcomes show an increase in recurrences (up to 10% over 10 years) and complications such as infections, chronic pelvic pain, tissue erosion, and implant displacement. Existing studies lack long-term comparative analyses of the three main techniques: retropubic urethropexy, transobturator inside-out, and outside-in approaches. Additionally, the role of magnetic resonance imaging in diagnosing the causes of treatment failure remains unresolved, limiting the potential for personalized rehabilitation approaches for patients.

Objective: to evaluate preliminary long-term outcomes of retropubic, transobturator inside-out, and outside-in urethropexy techniques using synthetic materials, identify recurrence risk factors, and compare patient satisfaction and complication rates.

Methods

A retrospective-prospective study included 525 women (2002–2022) subdivided by surgical technique (retropubic, inside-out, outside-in) and 75 women with unsatisfactory outcomes. Methods: medical record analysis, validated questionnaires (ICIQ-SF, WHOQOL-BREF), ultrasound, magnetic resonance imaging (MRI), and urodynamic study. Statistical analysis focused on recurrence rates, complications (e.g., de novo overactive bladder), and satisfaction.

Results

long-term analysis (5–20 years) revealed comparable recurrence rates across techniques: retropubic (3.6%), inside-out (3.3%), outside-in (3.8%). Retropubic urethropexy showed higher urinary retention (1.9% vs. 0.8% for transobturator) and late-onset overactive bladder (41.6% at 20 years). inside-out had lower mesh erosion (1.1% vs. 1.9% for outside-in) and higher satisfaction (89% vs. 76%). Obesity (body mass index >30 kg/m²) and prior pelvic surgery were key recurrence predictors. Chronic pain was more frequent after transobturator approaches (2.77-fold vs. retropubic).

Conclusions

all urethropexy techniques demonstrate similar long-term efficacy, but distinct complication profiles. Retropubic access carries higher risks of urinary obstruction and late overactive bladder, while transobturator approaches (inside-out/outside-in) are associated with chronic pain. surgeon experience (>200 procedures) significantly reduces recurrence risk. Individualized technique selection based on patient factors (body mass index, pelvic surgery history) are critical. Long-term monitoring is essential due to rising complication rates over decades.

Minimally Invasive Approach to Deep Infiltrating Endometriosis with Bowel Involvement: From Dissection Planning to Colorectal Resection

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Background

The aim of this video is to demonstrate the preparation of dissection plans and the technique of colorectal resection in the surgical management of deep infiltrating endometriosis involving the recto-sigmoid junction.

Methods

A 34-year-old woman, gravida 1 para 1, presented with symptoms of cyclical diarrhoea, rectal bleeding during menstruation, and chronic abdominal pain. She also reported dyspareunia and dyschezia. Her obstetric history included one caesarean section. Transvaginal ultrasonography revealed a 44 mm rectovaginal nodule with suspected rectal invasion. Magnetic resonance imaging showed a 4 cm endometriotic nodule infiltrating the rectum. Although colonoscopy findings were unremarkable, external compression was noted at 15 cm from the anal verge.

Laparoscopic endometriosis surgery with a potential colorectal resection was planned. Laparoscopy revealed dense adhesions between the posterior uterus and the recto-sigmoid junction. Bilateral ureters were identified at the pelvic brim, and the infundibulopelvic ligaments were visualized. Both ureters were dissected and lateralized up to the level of the uterine arteries. Pararectal spaces were developed bilaterally.

Adhesions between the uterus and rectum were carefully released. Extensive endometriotic lesions were observed on the recto-sigmoid junction. Resection of the recto-sigmoid segment was deemed necessary. Following mobilization of the rectum and mesenteric dissection, proximal and distal transection sites were defined. The distal margin was transected using a laparoscopic stapler. The proximal margin was externalized through a mini-laparotomy incision for extracorporeal anvil placement. A wound retractor was used to minimize contamination. After anvil placement, the bowel was returned to the abdominal cavity. A circular stapler was inserted transanally and connected to the anvil to complete the colorectal anastomosis.

Results

The patient was discharged on postoperative day seven without any complications.

Conclusions

Surgical excision of endometriotic nodules is essential in patients suffering from deep infiltrating endometriosis, including bowel involvement. Proper laparoscopic planning and, when indicated, colorectal resection requires advanced surgical expertise and multidisciplinary collaboration. Laparoscopy offers a minimally invasive and effective approach for managing such complex cases.

<https://player.vimeo.com/video/1085486956?autoplay=1>

ADOLESCENT-PACT: A Four-Pillar Framework to Transform Endometriosis Care in Adolescents

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Background

Endometriosis in adolescents represents a critical yet frequently mismanaged condition, with 1 in 6 young women experiencing chronic pelvic pain that often persists for years before diagnosis. Despite growing recognition of the disease's impact on quality of life, education, and mental health, adolescents continue to face profound care disparities, including diagnostic delays averaging 16 months and inconsistent surgical approaches. This audit evaluates current management practices and introduces ADOLESCENT-PACT, an innovative four-pillar framework designed to standardize and optimize care for this vulnerable population.

Methods

We conducted a comprehensive review of 54 adolescents (aged 14-19 years) who underwent diagnostic laparoscopy for pelvic pain between August 2021 and August 2024 at a tertiary referral centre. Data collection focused on four key domains: referral timelines, surgical approach (excision versus ablation), quality of laparoscopic documentation, and mental health comorbidities. Operative notes, histopathology reports, and clinical correspondence were systematically analysed to identify patterns of care and opportunities for improvement.

Results

The audit revealed significant variations in care quality across provider specialties. While endometriosis specialists achieved 100% excision rates with 94% histologic confirmation, general gynaecologists performed ablation in 57% of cases without tissue sampling. Documentation proved inadequate in 50% of negative laparoscopies, compromising future care planning. Mental health needs were evident but underrecognized, with 7% of patients having documented psychiatric comorbidities. Most alarmingly, the average 16-month delay from symptom onset to surgical evaluation exceeded established targets for optimal disease management.

Conclusions

ADOLESCENT-PACT delivers measurable solutions: **Priority Access:** Mandatory PAG referrals at 6-month symptom mark **Advanced Surgery:** Specialist-led see-and-treat laparoscopy **Comprehensive Documentation:** Mandatory 6-compartment imaging protocol **Timely Integration:** Embedded mental health screening + <6-month referral target

This structured approach provides clinicians with a memorable, actionable pathway to deliver consistent, high-quality care to adolescents with endometriosis. By standardizing management while addressing both physical and psychological aspects of disease, ADOLESCENT-PACT represents a transformative model for early intervention in this underserved population.

Laparoscopic Management of Deep Endometriosis, Involving a Large Bladder Nodule

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Background

This case report involves a rare case of an endometriotic nodule, invading the complete thickness of the bladder wall. These abstract aims to emphasize that; by performing a partial cystectomy operation a rare incidence of deep infiltrative endometriosis involving bladder can be cured with improved post operative pain scores.

Methods

A 39 years old patient who had a c-section in 2009 presented to Uludag University School of Medicine Department of Obstetrics and Gynecology with chronic pelvic pain (Visual Analogue Scale 8/10), cyclic dysuria (VAS 9/10), dyspareunia (VAS 7/10). During the physical examination of the patient a painful nodule was palpated on anterior cervical fornix and bilateral Sacro-uterine ligament tension and fibrosis was present. Transvaginal Ultrasound revealed that the left adnexa was adhered to the posterior corpus of uterus and the pouch of Douglas. The bladder wall was thickened and the mucosal lining had irregularities. Magnetic Resonance Imaging (MRI) was also similar to ultrasound findings. In order to visualize the endometriotic nodule a cystoscopy was performed and a full thickness infiltrative endometriotic nodule was detected. During the laparoscopic approach butterfly excision of the peritoneum covering rectovaginal pouch was performed and bladder was dissected as a result vesico-vaginal space and Retzius space were developed. A 4 cm endometriotic nodule on the dome of the bladder was then excised with circular incision. Primary suturing was done by a 3.0 barbed suture and a second layer of 3.0 polyglactin 910 suturing was performed to prevent urine leakage. The patient was then discharged from hospital in post operative second day with a urinary catheter.

Results

Our case had dyspareunia 4/10 , dysmenorrhea 5/10, dysuria 10/10 as initial pain scores that lead our team to the decision of laparoscopic endometriosis surgery. Using cystoscopy to localize the endometriotic nodule and visualize the possible infiltration to the bladder mucosa is essential in pre-operative planning; due to the fact that in mucosa infiltrated nodules simple shaving would not suffice and partial cystectomy is indicated. Recurrence is rare in partial cystectomy, in our case during the follow up period of ten months there had been no urinary tract endometriosis recurrence. In this case post-operative pain scores were considerably lower: dysmenorrhea 2/10, dysuria 0/10, chronic pelvic pain 0/10; except a slight deterioration of dyspareunia 6/10.

Conclusions

In conclusion, although, hormonal therapy can be useful, there is no gold standard therapy of bladder endometriosis that may lead endometriosis surgeons to prefer surgical approach. Partial cystectomy of a full thickness invasive endometriotic nodule is a safe and effective method of therapy that should be considered in patients with dire urinary system symptoms.

<https://player.vimeo.com/video/1079413079?autoplay=1>

Reconstructive Surgery of Vaginal Atresia After Previous Complicated Operation

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Background

In 2016, a 30-year-old woman was admitted to our clinic with complaints of urinary incontinence, infertility, and increased urination during intercourse. On examination, the vaginal mucosa appeared normal, and an atrophic uterine cervix was observed. Urine leakage from the right side of the vagina was also noted. Vaginal ultrasonography revealed a normal uterus and bilateral ovaries, and the bladder appeared empty. The vulva and external urethral orifice were normal; however, urethral catheterization was unsuccessful.

The patient's sexual development, hormone profile, and menstrual history were normal (menarche at age 12). She had been married for one year. She was unable to have intercourse on her wedding night and subsequently underwent surgery at another hospital

Methods

As a result, contrast-enhanced CT with fistulography was performed and revealed a vesicovaginal fistula. Laparoscopic surgery was planned. The uterus, ovaries, and Fallopian tubes were found to be normal. During dissection around the "fistula," it became apparent that the patient had isolated vaginal atresia, which had led to the bladder being opened vaginally. Consequently, intercourse had occurred for one year through the bladder.

The tactic of the surgery was changed and the bladder's anatomy with atretic vagina was reconstructed

.Results

Six months later, the patient underwent neovaginoplasty with skin graft transplantation, and satisfactory sexual intercourse was achieved. Subsequently, due to one year of unsuccessful spontaneous conception, the patient underwent in vitro fertilization (IVF) and delivered a healthy baby girl by caesarean section at 38 weeks of gestation on July 30, 2020.

Conclusions

Currently, the patient has a five-year-old daughter. However, she has developed vaginal stenosis due to cessation of sexual activity over the past two years. Menstrual bleeding remains normal, but she continues to use diapers due to persistent bladder dysfunction.

<https://player.vimeo.com/video/1092457413?autoplay=1>

Suggested algorithm for managing bowel harassment in v-notes surgery with demonstration of the concept

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Background

Bowel harassment is the term used to describe the dynamic interference of the bowel interrupting the flow of the operation. The bowel harasses the surgeon and prevents the surgeon from progressing in the next step to conclude the procedure. The process will require to the surgeon to slow, stop, assess and perform further steps before reassessing to resume progress. This observation was to be caused by the large or the small bowel. This is an analysis of the phenomenon to understand the reasons and make some suggestions to resolve the difficulty,

Methods

The phenomenon was observed by studying it in 35 cases of V- NOTES hysterectomy performed by one experienced surgeon performed in Epsom hospital in London, UK from 2023 to 2024. The following reasons were suggested for the phenomenon and that included high BMI or in cases where there was loss of weight. it was also observed when the anaesthesia was not adequate and possibly the spinal was helpful in reducing it. What sort of actions and their sequence were recorded and analysed.

Results

It was observed that large bowel is less mobile than the small bowel. the harassment caused increased concern in securely activate the energy device especially to seal and divide the IP ligaments and the round ligaments. The following algorithms was suggested to manage the problem. However for every step taken the surgeon should stop and assess the effect before moving to the next sequence;

1- ensure further adequate head down

2- repositioning on the bowel; adopt the following order, position the omentum over the stomach before trying to position the small bowel high up towards the liver area and then try to mobilise the large bowel, be aware that the large bowel is not necessary freely mobile

3- check if the patient is adequately anaesthetised with good relaxation before increasing the momentum intraabdominal pressure

4- consider introducing through the Alexis retractor in the POD a folded 35x35cm swab gauze as a third assistant to push the bowel away, register it in the swab counting

5- consider fourth port assistance and that can include fan like liver retractor

6-explore the presence of adhesions and consider adhesiolysis

7- Repeat the steps systematically if safe otherwise consider conversion or stop

Bowel harassment was observed to be predisposing factor for prolonged operative time, surgeons increased task demand and intraoperative complications. All the steps mentioned required robust

communication between the team members. Spinal anaesthesia and bowel prior bowel preparation are addition factors to evaluate for prevention of bowel harassment

Conclusions

This is a structured attempt to create a standard operating policy to manage a frequently observed difficulty that can seriously limit the success of v-notes surgery. It will need further validation and can also be studied in standard laparoscopy.

EYE vs ICG, Don't be Fooled

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Background

We are presenting a case of urinary tract anomaly i.e duplicate ureter encountered during Robotic Assisted Total Hysterectomy for endometriosis.

Methods

A 37-year-old lady underwent Robotic Assisted Total Hysterectomy + Bilateral Salpingo-oophorectomy and excision of endometriosis. Before surgery cystoscopy was carried out and intra-ureteric ICG was administered to help visualize the ureters.

Results

It was noted during surgery that there is a tubular structure lateral to the left ureter, which has peristaltic-like motion. The ureter was clearly seen with the help of ICG, but on careful dissection of the area, it was noted that this was a duplicate ureter. The lateral ureter had not taken up the ICG, most probably due to a separate opening into the bladder, which was not identified during cystoscopy. The right ureter was normal, and no duplication was noted.

Conclusions

Congenital anomalies of the kidney and urinary tract (CAKUT) encompass a spectrum of developmental disorders affecting renal and urinary structures. Among these, ureteral duplication (duplex collecting system) is the most common congenital urinary tract anomaly, occurring in ~1% of the population. Ureteral duplication arises from abnormal branching of the ureteric bud during embryogenesis, resulting in two ureters draining a single kidney.

Risk of iatrogenic ureteric injury increases significantly in cases of duplicated ureters. Visual ambiguity and limited exposure can result in complications like, accidental trauma, ischemic injury, or thermal damage. Pre-operative imaging, ureteric stenting/ICG administration can be helpful, but careful dissection should always remain the key in identifying possible anatomical anomalies.

<https://player.vimeo.com/video/1090278384?autoplay=1>

Urological Complications in Gynecological Surgery: Prevention, Diagnosis, and Management

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Background

Ureteral and bladder injuries are the most common urological complications in gynaecologic surgery. Contributing factors include intraoperative bleeding, adhesions, endometriosis, previous pelvic irradiation, pelvic masses, and obesity. The overall incidence of iatrogenic ureteral injury is reported between 0.5% and 10%, with 55% occurring during gynaecological interventions, followed by urological (25%), colorectal (15%), and vascular (5%) surgeries. Bladder injuries may occur at any stage of pelvic surgery and can result from both mechanical and thermal causes. Delayed thermal injuries due to electrosurgery are particularly challenging. Intraoperative identification is achievable in 84–94% of cases, with or without routine cystoscopy.

Methods

A retrospective analysis was conducted on gynaecological procedures complicated by urological injuries. Data collected included type of lesion (ureter, bladder, urethra), intraoperative diagnostic modalities (cystoscopy, indocyanine green fluorescence, methylene blue), type and timing of repair (immediate vs. delayed), postoperative follow-up, and clinical outcomes. Our aim was to assess the incidence, diagnostic strategies, and management of urological complications during gynaecological surgeries, with a focus on prevention and multidisciplinary collaboration, particularly in minimally invasive settings. The involvement of urology specialists was documented in all cases.

Results

Preventive strategies include direct visualization of the ureters, cautious use of diathermy, and meticulous dissection of the bladder from the uterus. In high-risk cases, prophylactic placement of ureteral catheters or double-J stents is recommended. If ureteral integrity is uncertain, intraoperative retrograde ureteropyelography should be performed. Ureteral injuries identified intraoperatively or within 72 hours are best managed with immediate surgical repair. Delayed diagnoses (>72 hours) require temporary urinary diversion, with definitive reconstruction postponed by at least six weeks. Minor injuries may be managed conservatively with stenting. Larger defects require end-to-end anastomosis or, if tension-free repair is not possible, reimplantation into the bladder with psoas hitch or Boari (Mező-Boari) flap. Bladder injuries are diagnosed intraoperatively using dye instillation or cystoscopy (especially in trigonal cases). Postoperative diagnostic tools include ultrasound, CT urography, and creatinine measurement from drain fluid. Small extraperitoneal injuries may be managed conservatively with catheterization for 14 days. Intraperitoneal injuries require surgical repair; for injuries smaller than 2 cm, a single-layer suture is sufficient; for injuries larger than 2 cm, a double-layer closure is recommended. Bladder injuries identified intraoperatively must be repaired immediately. Catheter drainage is typically maintained for 7 to 14 days.

Conclusions

Urological injuries during gynaecological surgery require prompt recognition and a structured, multidisciplinary approach. Prevention, intraoperative diagnosis, and appropriate surgical techniques are critical. Minimally invasive management in specialized centres is recommended to optimize outcomes and recovery.

The intravesical wanderer: Laparoscopic and cystoscopic management of a migrated intrauterine device

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Background

An Intrauterine Device (IUD) is generally a safe and effective contraceptive method, but rare complications such as uterine perforation and migration into the bladder can occur. This case demonstrates the management of a 53-year-old woman with a history of a perforating IUD within the bladder. A previous cystoscopic removal attempt three years prior was incomplete, and she subsequently presented with hematuria and pelvic pain. This video article aims to demonstrate the combined laparoscopic and cystoscopic approach for the complete removal of the migrated IUD.

Methods

The patient underwent a total laparoscopic hysterectomy with bilateral salpingo-oophorectomy and concurrent cystoscopic intervention. Surgically, pararectal and paravesical spaces were developed. Dense adhesions between the bladder and uterus, resulting from two previous C-sections, were meticulously dissected. The bladder was mobilized, and complete ureteral dissection was performed down to the ureterovesical junction. Concurrently, during cystoscopic examination, urinary stones that had formed around the IUD were fragmented and removed using a Holmium YAG laser. The IUD was then extracted from the bladder wall utilizing an advanced energy system. The resulting defect on the bladder wall was repaired with a 3/0 barbed suture. Before the operation, informed consent was taken regarding use of surgical video for scientific purposes without disclosing any personal detail

Results

The migrated intrauterine device and associated urinary stones were successfully removed in their entirety through the combined laparoscopic and cystoscopic approach. The bladder wall defect was repaired securely without immediate complication. The total laparoscopic hysterectomy with bilateral salpingo-oophorectomy was also completed successfully. The patient experienced a resolution of her presenting symptoms of hematuria and pelvic pain following the procedure.

Conclusions

Laparoscopy combined with concurrent cystoscopy provides a safe and effective minimally invasive approach for managing complicated cases of intravesical IUD migration, even in the presence of dense adhesions or following previous incomplete removal attempts. This combined technique facilitates complete IUD extraction, stone removal, and definitive repair of the bladder defect, leading to successful patient outcomes.

<https://player.vimeo.com/video/1090217258?autoplay=1>

Prevention and management of urinary complications in laparoscopic surgery: A video vignette

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Background

Urinary tract complications are not uncommon in gynecologic laparoscopic surgery, especially with the rising number of repeat caesarean sections and prior abdominal surgeries. Every gynecologic surgeon should be equipped with the knowledge and skill to both prevent and effectively manage such complications.

Methods

This is a video-based presentation showcasing real-case scenarios involving urinary tract complications during laparoscopic gynecologic surgery.

Results

The video presents several techniques aimed at preventing urinary tract injuries, including the use of a three-way Foley catheter to fill and delineate the bladder, proper bladder dissection technique, moving from lateral to medial, the prophylactic placement of Double J (DJ) stents in selected high-risk cases. Additionally, the video illustrates the intraoperative management of complications such as inadvertent bladder perforation in a patient with megacystis, vesicovaginal fistula, thermal injury to the ureter, ureteral transection during unilateral salpingo-oophorectomy (USO)

Conclusions

While urinary tract injuries can be minimized through meticulous technique and preventive strategies, they may still occur, particularly in complex cases. Key preventative measures include the use of a three-way Foley catheter, cautious and anatomically correct bladder dissection, limited use of electrosurgery near the urinary tract, and routine identification of the ureter in challenging cases. The retroperitoneal approach and prophylactic DJ stent placement may further reduce ureteral injury risk. When complications do occur, prompt intraoperative recognition is critical for optimal outcomes.

<https://player.vimeo.com/video/1090200528?autoplay=1>

Laparoscopic retrieval of a perforated intrauterine device into rectum: a rare case in a single institution

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Aim

Demonstrate a rare complication of intrauterine devices (IUDs) perforation into bowel, and raise awareness that perforation of the uterus by IUDs can occur.

Background

Uterine perforation is an uncommon complication of IUD insertion, with an incidence of one in 1,000 insertions, it can often be asymptomatic. The most common mechanism is that the device is forced into or through the uterine wall at the time of insertion. Very rarely, a device may perforate into bowel or the urinary tract.

Materials / Patients

A 28-year-old woman, gravida 4, para 4, was spontaneously pregnant despite intrauterine device (IUD) insertion at postpartum visit of her third child. IUD was not found in the uterus during her subsequent caesarean delivery. Three months after her delivery, she was highly suspected of IUD perforation into bowel due to her symptoms of persistent abdominal pain.

Methods / Results

We arranged KUB for her persistent lower abdominal pain, and the result showed highly suspected IUD perforation. Therefore, we arranged laparoscopic retrieval of a perforated IUD into bowel.

Discussion

Puerperal insertion is one of causative factors in perforated IUD into bowel, not only in our case, but also other case reports. These patients developed gastrointestinal symptoms only after a subsequent labour and delivery. Significant morbidity was present in most patients, and the diagnosis was often delayed and difficult to establish.

Conclusion

An extrauterine device should be removed promptly to minimize the risk of developing serious gastrointestinal complications.

Impact to Patients' Health

An extrauterine device should be removed promptly to minimize the risk of developing serious gastrointestinal complications.

<https://player.vimeo.com/video/1089775917?autoplay=1>

Laparoscopic vesicovaginal fistula repair in a patient with a history of radiotherapy for cervical cancer

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Background

Radiotherapy can cause complications in the treatment of cervical cancer.

Methods

A 48-year-old nulliparous woman was diagnosed with cervical cancer 5 years ago and had a history of radiotherapy. On gynaecological examination, the vagina was stenotic, and no mass was observed. Pap smear showed high-grade squamous intraepithelial lesion (CIN-III), but squamous cell carcinoma could not be excluded. Therefore, clinical correlation and biopsy were recommended. MRI showed diffuse increase in bladder wall thickness. Lumen signal intensity was normal. Uterus appeared atrophic. Pathological increase or deformable mass structure could not be distinguished on post-contrast images. The appearance may represent fibrotic changes due to radiotherapy. Upon monitoring of urine flow during LEEP, a 1 cm defect in the bladder was repaired vaginally. The patient had no discharge for 2 days after the operation, and when vaginal urine discharge was observed on the second day, a decision was made to operate. Informed consent was obtained. Laparoscopic vesicovaginal fistula repair, radical hysterectomy, and omental transposition were performed.

Results

During the operation, it was observed that the bladder, uterus, rectum was densely adherent secondary to radiotherapy. To reach the fistula tract, a sharp dissection was used to separate the vesicovaginal space. However, since the uterus was fibrotic and did not allow the area to be monitored, it was decided to remove it. Bilateral ureters were identified and lateralized with sharp dissection. The uterine artery and vein were calcified and cut by grasping where they originated from the bilateral hypogastric arteries. The lateral parametrium was separated from the ureters. The dorsal parametrium was separated from the rectum and ureter and included in the specimen. The uterus was resected by colpotomy. The defect at the base of the bladder could be reached in this way. The vagina was observed to be quite tense due to radiotherapy. The vaginal mucosa was separated from the bladder, but it was thought that the fistula tract in the bladder could not be closed due to fibrosis and that it could further enlarge the defect in the bladder. Therefore, it was decided to mobilize the bladder. A cystostomy was performed from the fundus of the bladder and a defect was seen at the bladder base. The fistula orifice with impaired nutrition was removed. The defect line was repaired with 3-0 Vicryl suture. It was checked with methylene blue and no leakage was observed. Bilateral ureteral orifices were seen normal. The cystostomy line was closed according to the procedure. The omentum was partially separated from the transverse colon and sutured to the repair line.

Conclusions

The patient was discharged without any complications. Nephrostomy catheters were removed on the 15th postoperative day. No leakage was observed.

<https://player.vimeo.com/video/1085836351?autoplay=1>

Laparoscopic management of complete uterine inversion in a non-pregnant patient is feasible but is highly challenging!

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Background

Background : To present the rare case of complete uterine inversion in a non-pregnant young woman who was managed successfully laparoscopically.

Methods

Methods: A 24-years-old patient with a past history of laparotomic staging for a granulosa-cell ovarian tumor, was referred to our Unit for laparoscopic management of complete uterine inversion. She had recently undergone an unsuccessful emergency vaginal procedure under laparoscopic control, to manage intractable uterine bleeding, that failed to reverse the inversion, and resulted in partial vaginal resection of a large adenomyotic lesion, followed by placement of several haemostatic uterine sutures.

Results

Results: The uterine inversion was successfully reversed with a combination of laparoscopic and vaginal maneuvers after vertical anterior and posterior uterine incisions to divide the cervical constriction ring. The uterine cavity was opened, previous sutures were removed and the uterus was reconstructed with re-suturing in two layers. A prophylactic cervical cerclage tape was placed laparoscopically. At six months follow-up, the patient reported irregular cycles, without menorrhagia and had a fairly normal-shaped uterus.

Conclusions

Conclusions: Successful laparoscopic management of uterine inversion in non-pregnant patients with fertility preservation has been rarely reported. It is feasible, but represents a most challenging procedure when fertility preservation is at stake

<https://player.vimeo.com/video/1085823712?autoplay=1>

Management Of False Passage In The Myometrium After The Hysteroscopy: Case Presentation

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Background

Hysteroscopy is a common and valuable diagnostic and therapeutic procedure in gynecology, specifically for assessing uterine abnormalities associated with infertility. Although rare, the creation of a false uterine passage, commonly referred to as a false cavity, can occur during hysteroscopic interventions. Anatomic variations such as retroverted uterus or hyperanteflexed uterus may predispose patients to this complication, leading to clinical challenges.

Methods

In this case presentation, we present a 26-year-old woman with primary infertility who sought medical intervention due to her desire to conceive. She had no significant medical or surgical history. The patient underwent hysteroscopy for infertility evaluation, during which an inadvertent false cavity was created and an embryo was transferred to the false cavity. Following this complication, the patient was referred to our clinic for further evaluation and management. A diagnostic hysteroscopy and laparoscopic exploration were planned to assess the extent of the complication. During the hysteroscopy, a false passage was identified in the posterior uterine wall. Subsequently, laparoscopy was performed, revealing the passage of methylene blue through both fallopian tubes and into the posterior wall of the uterus, thus confirming uterine perforation. The posterior uterine wall was successfully repaired using absorbable sutures and the operation was terminated with control hysteroscopy to observe the integrity of the uterine cavity.

Results

False passages in hysteroscopy are more likely to occur during cervical dilation in scenarios involving stenotic cervices, acute anteflexion, or retroflexion of the uterus. The diagnosis of a false cavity or passage is confirmed by visualizing normal anatomical landmarks, including the tubal ostia and endometrial glands. In this case, the reconstruction of the uterine cavity was successful, and postoperative assessment indicated the restoration of normal uterine anatomy.

Conclusions

This case underscores the necessity for increased awareness of possible complications associated with hysteroscopic procedures and the importance of employing appropriate techniques to minimize risks. Preoperative ultrasound imaging may serve to identify anatomical variations that could predispose patients to complications. In instances of uterine perforation, timely laparoscopic repair is essential to prevent further complications. This case contributes to a rare but important complication of hysteroscopy, ultimately aiming to improve patient safety and fertility treatment success.

<https://player.vimeo.com/video/1085759137?autoplay=1>

Major vascular injury, a fatal but avoidable complication in laparoscopic surgery – A Step-by-Step new approach to prevention and management.

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Background

Laparoscopic surgery is the standard of care in benign gynecology, with approximately 250,000 procedures performed annually in the UK. Although major vascular injury is rare (0.1–1.1%), it remains one of the leading causes of mortality in laparoscopy, particularly during blind entry using the Veress needle or trocar. Around 75% of vascular injuries occur during primary entry, with 50% of all laparoscopic complications linked to this stage. Early recognition and systematic management are essential to improve outcomes.

Methods

We present the case of a 29-year-old woman undergoing diagnostic laparoscopy for pelvic pain and infertility, who re-presented with abdominal pain 24 hours post-discharge. CT Abdomen and Pelvis revealed a large retroperitoneal haematoma (13cm) near the right common iliac artery with suspected active bleeding due to contrast extravasation. A multidisciplinary approach was undertaken, involving urgent collaboration with interventional radiology. Conservative management with close monitoring was agreed following angiography (Percutaneous Trans-arterial embolization (TAE), which excluded ongoing bleeding. A repeat CT angiogram after 24 hours confirmed no active bleeding. She was discharged after 48 hours, with outpatient follow-up arranged. A Datix report was submitted for governance review. Drawing on this case and literature, we developed a **step-by-step guide** and introduced a novel **BLEED** mnemonic (**B**rief history, **L**ocate bleed, **E**scalate early, **E**xecute control, **D**ebrief) to guide surgical teams during vascular emergencies.

Results

Vascular injury during laparoscopy can have devastating consequences. Our case highlights the importance of vigilance beyond the immediate postoperative period. The patient remained hemodynamically stable; therefore, interventional radiology (IR)-guided embolization was considered a safe and appropriate alternative to laparoscopic or open surgical repair. Such injuries, though rare, typically occur during Veress needle or trocar insertion and may go unrecognized at the time of surgery; particularly when involving major vessels or retroperitoneal structures. Conservative management is viable in selected cases with appropriate imaging and MDT support. Standardizing emergency response using a mnemonic and embedding this within simulation training for vascular injury offers a proactive strategy to improve safety and outcomes.

Conclusions

This case highlights the urgent need to recognize delayed presentations of vascular injury following laparoscopy. In response, we propose a new step-by-step guide for the recognition and management of these injuries, supported by a visual emergency management diagram to assist intraoperative decision-making. The BLEED mnemonic offers a clear, structured framework that promotes early recognition, timely escalation, and coordinated team responses. Combined with our reproducible

simulation model, this approach aims to improve preparedness, strengthen teamwork, and ultimately enhance patient safety. Integration into gynaecological surgical training is planned to embed these tools into routine clinical practice.

Peri-operative Outcomes of Operative Hysteroscopy: Five-Year Retrospective Cohort Study of 164 Procedures in a Tertiary Gynaecology Unit

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Background

Operative hysteroscopy is the preferred modality for treating a spectrum of intra-uterine pathologies, yet comparative data on procedure-specific safety and haemodynamic impact remain scarce. We analysed peri-operative complications, haemoglobin (Hb) dynamics, transfusion requirements, and length of stay across common operative hysteroscopy techniques performed in a tertiary referral centre.

Methods

All consecutive operative hysteroscopies undertaken between 2019 and 2024 were retrospectively reviewed (n = 164). Retrospective data was acquired following approval from hospital administration. Interventions were grouped as hysteroscopic myomectomy (HM; n = 99), retained placental tissue removal (RPT; n = 15), septum resection (SR; n = 47), and T-shaped cavity correction (TS; n = 3). Primary endpoints were intra- and post-operative complications (Clavien–Dindo), peri-operative Hb change, packed-cell transfusion, and postoperative length of stay (LOS). Statistical analyses (SPSS v26.0) included χ^2 or Fisher's exact tests for categorical variables, Kruskal–Wallis for non-parametric continuous data, and odds ratios (OR) with 95 % confidence intervals; significance was set at $p < 0.05$.

Results

The overall complication rate was 3.7 % (6/164). SR exhibited a higher complication incidence (8.5 %) than the composite of other procedures (1.7 %), bordering statistical significance ($p = 0.057$). LOS differed significantly among groups (Kruskal–Wallis $p = 0.006$): median 1 day for SR and TS versus 2 days for HM and RPT; the longest stay (19 days) occurred after RPT.

Peri-operative Hb change was evaluable in 47 patients: mean decline 0.47 g/dL (HM), 0.61 g/dL (SR), 0.90 g/dL (TS), and 1.45 g/dL (RPT) ($p = 0.013$). Six patients (3.7 %) required transfusion; RPT had a higher, though non-significant, transfusion rate (13.3 %) versus other procedures (2.7 %; OR = 5.6, $p = 0.095$). Pathology-stratified analysis corroborated a greater Hb drop in placental tissue cases (1.67 g/dL) compared with non-placental cases (0.45 g/dL, $p = 0.017$) without a significant difference in transfusion frequency (16.7 % vs 4.0 %, $p = 0.13$). Patient age was not associated with complication risk ($p = 0.68$; OR = 0.96 per year, $p = 0.37$).

Conclusions

Operative hysteroscopy demonstrated low overall morbidity. Septum resections carried the highest complication propensity, while retained placental tissue removals incurred the greatest haemoglobin loss, transfusion demand, and prolonged LOS. These findings underscore the need for procedure-specific pre-operative counselling, meticulous intra-operative haemostasis, and tailored postoperative monitoring to optimise outcomes.

Laparoscopic Management of a Perforated Intrauterine Device Involving the Uterus, Sigmoid Colon, and Ovary: A Multidisciplinary Approach

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Background

This video presents a complex case of a perforated intrauterine device (IUD) in a 35-year-old woman, highlighting multidisciplinary coordination, surgical decision-making and laparoscopic technique in the context of bowel involvement.

Methods

The patient was referred to gynaecology for failed removal of an IUD in primary care. She reported heavy menstrual bleeding, abnormal pelvic pain and dyschezia. A transvaginal ultrasound revealed an incorrectly sited IUD with one arm embedded in the myometrium and one perforating towards the right ovary.

Diagnostic hysteroscopy confirmed the stem of the coil traversing the uterine fundus, with arms not visible in the uterine cavity. Diagnostic laparoscopy identified the right arm of the IUD protruding through the uterine serosa, with dense adhesions tethering the sigmoid colon and right ovary to the uterine fundus.

Initial adhesiolysis was performed but due to the risk of bowel injury, potential need for resection, fistula formation, requirement for bowel preparation and informed patient consent, the case was abandoned delayed to be performed as a joint case with colorectal surgeons. Flexible sigmoidoscopy was considered but deemed of limited utility.

Results

Definitive surgery was performed with full bowel preparation and consent. The procedure was performed as a joint case and involved laparoscopy, adhesiolysis between the sigmoid colon and uterus, sigmoid epiploicae and uterine suturing. Part of the arm of the coil was not retrieved. Concurrent hysteroscopy showed no evidence of retained coil fragments in the endometrium and postoperative imaging confirmed a retained linear hyperechoic fragment in the right ovary, likely the coil remnant. Ultimately bowel resection was not required.

Conclusions

This case illustrates the potential for IUCD migration, the importance of imaging in preoperative planning and the value of multidisciplinary planning in optimising patient safety and surgical outcomes.

<https://player.vimeo.com/video/1085604406?autoplay=1>

Laparoscopic Intervention for Displaced Intrauterine Device: Adhesiolysis Case Involving the Bowel and Appendix

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Background

Intrauterine contraceptive devices (IUCDs) are one of the most common and dependable methods for long-term pregnancy prevention. Peruse options in the market, and it is hard to miss that these sutures tend to have a better acceptance rate. Pregnancy IUCDs, while being mostly safe, aren't entirely free of complications. Most nagging conditions include dislocation from its position or more severe uterine perforation. In cases like these, it isn't unusual for the device to anchor itself to the nearby organs like the intestine, appendix, or even omentum. Every so often women may present with nonspecific symptoms: a dull ache in the lower abdomen or unusual discharge. Some women may present with no symptoms at all and can get the underlying issue only during routine checkups. To avert potential damage to weeping, malfunctioning organs, severe infections, or undo tissue scarring in the body, acting earlier on the case is critical. For these cases, safe removal of IUCDs does tend to become the most prudent choice for surgery due to minimal impact and quicker recovery time.

Methods

Six months following postpartum NOVA T IUCD insertion, a multiparous lady of 41 years old presented with ongoing vaginal discharge. IUCD migration into the anterior myometrium with corresponding left-sided hydrosalpinx was discovered by transvaginal and 3D ultrasound imaging. A healthy cervix with evident IUCD threads and no intracavitary device—a sign of extrauterine migration—was confirmed by diagnostic hysteroscopy. A large, retroverted uterus was discovered by laparoscopy, with the IUCD adhering to the appendix, ileal loop, and omentum and lodged in the right fundal-cornual area. There was no visible abscess or loose fluid. Adhesiolysis was done carefully. A laparoscopic appendectomy was performed due to an unfavourable appendix tip. Bilateral salpingectomy, ileal Serosal repair, and IUCD extraction were all performed successfully.

Results

After the successful laparoscopic removal of the IUCD, there were no after effects and all symptoms completely disappeared. The appendix's histopathology showed persistent inflammation. The patient made a full recovery and was released in a stable state.

Conclusions

Significant pelvic adhesions and structural disruption can result from displaced IUCDs. Safe removal and accurate diagnosis are made possible by a combination hysteroscopic-laparoscopic technique. Laparoscopy is the recommended procedure in challenging IUCD displacement situations because it minimizes complications and enables organ-preserving care.

<https://player.vimeo.com/video/1085488725?autoplay=1>

Conservative Laparoscopic Management of Retroperitoneal Vascular Injury During Veress Needle Entry: A Case Report in a high BMI Patient Undergoing Diagnostic Laparoscopy for Subfertility

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Background

Vascular injury during laparoscopic entry is an uncommon but significant complication. When it occurs during closed entry with a Veress needle, immediate detection and a strategic intraoperative response are vital to patient safety. We report a case in which such an injury was managed conservatively with a minimally invasive approach preserved.

Methods

To describe a rare case of retroperitoneal vascular injury during Veress needle entry in diagnostic laparoscopy for subfertility, highlighting the value of early recognition, secondary entry technique, and conservative management using intraoperative imaging to avoid conversion to laparotomy.

Results

A 31-year-old patient with Body Mass Index of 48 undergoing laparoscopy for subfertility experienced intravascular placement of the Veress needle at the umbilicus, identified immediately during Palmer's test by aspiration of blood. The needle was left in situ, and safe alternative access was achieved via Palmer's point. Laparoscopic inspection revealed a retroperitoneal haematoma without evidence of active bleeding.

To confirm stability and avoid disrupting the haematoma surgically, the patient was transferred under anaesthesia for a CT Angiogram, which confirmed no active bleeding with a stable hematoma. The laparoscopy was completed, showing no endometriosis and patent fallopian tubes. The patient remained stable and did not require conversion to open surgery. During 3 months follow up, the patient reported symptoms of meralgia paresthetica, likely secondary to intraoperative positioning, and was successfully managed with amitriptyline. MRI was arranged to monitor the haematoma.

Conclusions

This case highlights the importance of prompt recognition of vascular injury during Veress needle entry especially in High BMI cases. A combination of secondary laparoscopic access, careful inspection, and intraoperative CT imaging enabled a safe, conservative approach without haematoma disruption or laparotomy. Such strategies are critical for preserving the benefits of minimally invasive surgery, particularly in fertility-related procedures.

Uterine myometrial stiffness in primary dysmenorrhea: Preliminary results

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Background

Primary dysmenorrhea is a common gynaecological condition among young women, often affecting their quality of life. Although several hypotheses have been proposed, its etiopathogenesis remains controversial. This study aimed to assess myometrial stiffness in women with primary dysmenorrhea using ultrasound elastography.

Methods

This prospective observational study was approved by the institutional ethics committee, and informed consent was obtained from all participants. Twenty-four women diagnosed with primary dysmenorrhea were included in the preliminary analysis. Demographic data and menstrual pain severity were recorded using the verbal multidimensional scoring system (VMSS). Transabdominal ultrasound elastography was performed using the Mindray Resona I9 system with a convex probe (SC6-1) by a single-blind radiologist. Initially B-mode imaging was used to assess uterine morphology. Subsequently, shear wave elastography (SWE) was applied to evaluate myometrial elasticity. Cine loops were acquired in both sagittal and axial planes, and the most stable frames with high reliability indices were selected for measurement. Elasticity values (minimum, maximum, and mean in kilopascals) were calculated separately for the anterior and posterior uterine walls in both planes. All data were analysed using SPSS V 25.0.

Results

The median age of the participants was 24 years (18–31). median elasticity values of the posterior corpus were 8.8 kpa (longitudinal) and 9.61 kpa (axial), while anterior corpus values were 11.93 kpa (longitudinal) and 10.09 kpa (axial). The average maximum VAS score was 7 ± 2 and minimum VAS score was 3 ± 2 . The mean number of heavy bleeding days was 2 ± 1 , and total menstrual bleeding averaged 5 ± 1 days. Four patients (16%) were smokers. No statistically significant correlations were found between elasticity values and clinical parameters, including vas scores, uterine dimensions, or menstrual bleeding features. This lack of association may be due to the limited sample size. Additional recruitment is ongoing to strengthen statistical power and further investigate these relationships.

Conclusions

In this preliminary analysis, uterine myometrial elasticity, as measured by shear wave elastography, did not correlate with pain severity in patients with primary dysmenorrhea. These findings suggest that dysmenorrhea may be more closely associated with biochemical or molecular processes than with structural uterine stiffness. However, as this analysis is based on preliminary data, further results may differ once the targeted sample size is reached and a matched control group is included.

Uterine peristalsis as a predictor of pain during intrauterine device insertion: a prospective cohort study

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Background

To identify and validate differences in uterine contractions as a potential cause for increased pain associated with intrauterine device (IUD) insertion.

Methods

This prospective observational cohort study included patients aged 18 years or older scheduled for first time IUD insertion at the Catharina Hospital, Eindhoven. All participants underwent a 2-4 minute transvaginal ultrasound (TVUS) immediately before and after IUD insertion. Uterine peristalsis (UP) was assessed using a dedicated speckle tracking algorithm. UP parameters were compared pre and post insertion using paired T-test or Wilcoxon signed ranks test. Pain was assessed using a visual analogue scale (VAS) and dichotomized into scores <8 or ≥ 8 . Univariable logistic regression analysis was used to identify potential predictors of high pain scores ($p < 0.1$); significant variables were included in multivariate models.

Results

A total of 49 women were included, 26 with VAS score below 8 and 23 with VAS score of 8 or above. Baseline characteristics did not differ significant between the groups.

After IUD insertion, contraction direction shifted significantly from cervix-to-fundus (C2F) to fundus-to-cervix (F2C) on both the anterior and posterior uterine walls ($p=0.04$ and $p<0.01$, respectively). Coordination of uterine contractions increased post-insertion ($p=0.04$). Univariable analysis identified parity (OR 0.32, 95% CI 0.10-1.05) and hormonal contraceptive use (OR 3.45, 95% CI 1.02-11.67) as potential predictors of higher pain scores ($p < 0.1$).

Adjusted multivariable models revealed the following pre-insertion UP features as independent predictors of higher pain:

- Mean contraction frequency in longitudinal direction (posterior wall) (OR 0.00, 95% CI 0.00–0.56, $p=0.03$);
- Mean and median contraction frequency in radial direction (posterior wall) (OR = 0.02, 95% CI 0.00–0.84, $p=0.04$; (OR = 0.00, 95% CI 0.00–0.46, $p = 0.02$) respectively);
- Coordination (OR 1.13, 95% CI [1.02–1.26], $p = 0.02$).

Parity remained a significant predictor for pain in models with mean and median contraction frequency, ($p<0.01$, $p=0.02$ and $p=0.01$ respectively).

Conclusions

IUD insertion appears to induce a reversal in contraction direction and increased coordination of uterine activity. Additionally, specific pre-insertion UP characteristics may predict pain severity,

suggesting a potential role of uterine contractility in pain perception during IUD placement. Further research is warranted to explore these findings.

Impact of retained products of conception on uterine peristalsis measured by ultrasound speckle tracking

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Background

RPOC are a common postpartum or postabortion complication, often presenting with bleeding, pain, or fever. Diagnosing RPOC is challenging because no definitive gold standard exists. Uterine peristalsis has been well studied during the menstrual cycle, but how it changes with intrauterine pathology like RPOC is not well understood. Speckle-tracking via transvaginal ultrasound (TVUS), validated in naturally cycling and IVF populations, provides a non-invasive, continuous, objective assessment of uterine contractility. This study uses this technique to assess whether RPOC affects uterine peristalsis and to explore its diagnostic role.

Methods

This prospective observational cohort study, part of the multicentre WAVES study, was conducted from 2022 to 2025 at the Department of Obstetrics and Gynaecology, Catharina Hospital in Eindhoven, the Netherlands.

52 women with postpartum or post-miscarriage bleeding underwent standardized TVUS. Suspected RPOC cases underwent diagnostic hysteroscopy to determine the presence or absence of RPOC. RPOC was confirmed in 42 cases and excluded in 10. Uterine contractility parameters—contraction frequency (per minute), peak amplitude, wave propagation direction, and coordination of anterior and posterior wall motion—were measured using a dedicated 2D speckle-tracking algorithm targeting the uterine junctional zone. These parameters were compared between the RPOC and non-RPOC groups using nonparametric tests ($p < 0.05$ for significance).

Results

Baseline characteristics (age, BMI, obstetric history) and most ultrasound findings (uterine size, endometrial thickness, structural abnormalities) were similar between groups. However, the RPOC group had a shorter interval from pregnancy to diagnosis (median 8 vs 11 weeks, $p = 0.012$) and, as expected, higher vascularity: 76.2% was classified as Gutenberg Type 2–3 (moderate–high) versus 100% Type 0–1 (none–minimal) in the non-RPOC group ($p < 0.001$).

A significant difference was found in contraction direction in the anterior wall: women with RPOC had a predominant fundus-to-cervix wave pattern (median 0.048), while those without RPOC showed a cervix-to-fundus pattern (median -0.218) ($p = 0.009$).

Conclusions

Women with RPOC showed predominantly fundus-to-cervix contraction patterns in the anterior uterine wall, whereas those without RPOC had cervix-to-fundus propagation. This reversal may reflect a physiological mechanism facilitating the expulsion of retained intrauterine tissue.

Uterine contractility in women with postmenopausal bleeding differs depending on type of pathology: The waves study

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Background

The development of a non-invasive diagnostic tool to discriminate benign from malignant endometrial pathology is of great importance for women presenting with postmenopausal bleeding in gynaecology. The aim of this study was to investigate potential differences in uterine contraction features, assessed via transvaginal ultrasound (TVUS), between benign versus malignant causes for postmenopausal bleeding.

Methods

In this single-centre prospective observational cohort study, women presenting with vaginal bleeding between 2022 and 2025 were recruited at the Catharina Hospital in Eindhoven, the Netherlands. Exclusion criteria included: a history of hysterectomy, endometrial ablation, or the presence of an intrauterine device. All participants provided informed consent. Each participant underwent TVUS, and a blood sample was collected to analyse female hormone levels. If endometrial thickness exceeded 4 mm, an endometrial biopsy was performed. Uterine contractility was analysed using a quantitative speckle tracking algorithm in MATLAB. Contraction characteristics – including frequency, amplitude, velocity, coordination and direction – were assessed for both overall longitudinal and radial orientations and anterior (AW) and posterior wall (PW) separately.

Results

Fifty-seven women were included (median age 57 years, IQR 12; median BMI 27.4 kg/m², IQR 8.7). Among them, 5 were diagnosed with endometrial carcinoma (EC), 8 with endometrial polyps and 44 had atrophic, normal, or minor proliferative endometrium. Thirteen women had uterine fibroids, and 9 women were using hormonal replacement therapy. Women with EC were older (72 years, IQR 6) than women without EC (55, IQR 6; P=0.001). Median contraction velocity from cervix to fundus was higher in women with benign pathology with 0.62 millimetres/second (IQR 0.27) than 0.38 millimetres/second (IQR 0.36) in women with EC (P=0.035). Contraction frequency did not differ between women with polyps, EC or women with normal endometrium (the overall mean of 1.37 (± 0.20) in all women with postmenopausal bleeding). Contraction amplitude tended to be lower in women with EC (median 0.050 IQR 0.045) than in those with a polyp (median 0.086 IQR 0.046; P = 0.056) in the AW, longitudinally. In the radial direction, women with polyps showed a higher median amplitude (0.069, IQR 0.042) than women with normal endometrium (0.041, IQR 0.040; P = 0.057). In the PW, amplitude of radially directed contractions was also more pronounced in women with polyps (0.070, IQR 0.040) than in women with normal endometrium (0.045 IQR 0.026; P=0.056). No other contraction parameters or hormone levels showed significant differences between groups (P>0.05).

Conclusions

This study suggests that speckle tracking on TVUS can detect distinct uterine contractility patterns associated with different causes of postmenopausal bleeding. These preliminary findings necessitate validation in larger cohorts.

A dedicated and accessible one-stop clinic for women with suspected endometriosis: one year of experience in a tertiary referral centre

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Background

Advanced endometriosis ultrasound is an accepted modality for the investigation of endometriosis that offers unique benefits when compared to other diagnostic modalities.

We describe our experience of establishing and running a one-stop clinic for women with suspected endometriosis in a tertiary referral hospital in the United Kingdom.

Methods

This is a descriptive quantitative study of our experience in a one-stop clinic in a tertiary referral hospital in the United Kingdom. We performed a retrospective analysis of one year of activity with the aim of describing the patients' pathway of care between August 2022 and July 2023. Data were collected on the patients' symptoms including abnormal vaginal bleeding or menorrhagia, pelvic pain, bowel symptoms, urinary symptoms, sexual function, and fertility-related issues.

Transvaginal ultrasound was performed and documented following standard steps for evaluation of suspected endometriosis. We recorded data regarding the diagnosis and the agreed management plan. Data were presented with descriptive statistics. Associations between categorical variables were calculated with Pearson's Chi square test, or Fisher's exact test.

Results

142 cases were reviewed. 105 patients (73.9%) had a single clinical visit and the mean number of scans performed per patient was 1.35. 127 women (89.4%) received a definitive diagnosis of deep endometriosis and/or adenomyosis. 82 (57.7%) were diagnosed with two or more concomitant conditions. Adenomyosis and deep endometriosis were both present in 47 (33%) of patients. Adenomyosis was found alongside pelvic floor muscle dysfunction in 24 patients (16.9%).

Medical management was prescribed or modified for 71 (50%) of patients, with 38 (26.8%) as first line approach, and 33 (23.2%) as a bridge to further surgery or fertility treatment. 55 (38.7%) patients opted for surgery, of which 13 (9.2%) did so in the context of fertility treatment.

Conclusions

Our findings demonstrate the utility of a one-stop clinic in providing comprehensive care including diagnosis, treatment planning, and referral for multidisciplinary discussion when necessary. The one-stop clinic offered an opportunity to explore a patient's history, symptoms, and priorities comprehensively. This holistic approach is crucial in endometriosis care, where symptoms can be diverse and impact various aspects of a woman's life. The high rates of pelvic pain (89%), dyspareunia

(46%), and subfertility (37%) in our cohort highlight the significant impact of endometriosis on quality of life and reproductive health.

The high rate of diagnosis, efficient management planning, and integration of multidisciplinary care planning suggest that this model could be beneficial if implemented more widely. The ability to offer expert ultrasound, discussion of management options, and provide multidisciplinary care in a single visit represents a significant advancement in the care pathway for women with suspected or previously diagnosed endometriosis. Future research in this area may address long-term outcomes, patient satisfaction with this approach, and its cost-effectiveness compared to traditional care pathways.

Lymphadenectomy with CUSA: A Case of Nodal Recurrence of HGSOC

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Background

Pelvic recurrence of high-grade serous ovarian cancer (HGSOC) presents considerable surgical challenges due to extensive fibrosis, anatomical distortion, and proximity to critical vascular and nervous structures. The Cavitron Ultrasonic Surgical Aspirator (CUSA) offers a refined surgical tool for selective tissue dissection. This study proposes a strategic, precise, and safe three-step approach integrating CUSA technology with real-time intraoperative ultrasound and a no-touch en-bloc resection technique to optimize oncologic control while minimizing perioperative morbidity in patients with pelvic recurrence of HGSOC.

Methods

A standardized three-step surgical protocol was applied in selected patients undergoing secondary cytoreductive surgery for pelvic recurrence of HGSOC, focusing on the following:

-CUSA-Assisted Surgical Dissection: CUSA was employed for the selective fragmentation and aspiration of peri-tumoral tissue, particularly useful in fibrotic or previously irradiated planes. Its ultrasonic energy allowed controlled ablation of the fibrotic peri-tumoral tissue while sparing blood vessels and nerves. This facilitated the safe debulking of recurrent lesions located in anatomically complex pelvic compartments.

-Ultrasound-Guided Precision Mapping: Intraoperative ultrasound was utilized to define tumor margins, identify residual disease, and assess the spatial relationship between the lesion and adjacent organs or major vessels. This image-guided approach enhanced anatomical accuracy, enabling the surgeon to perform precision resection, particularly in areas obscured by scarring or post-treatment anatomical changes.

-Vascular-Nervous Control and No-Touch En-Bloc Resection: Critical vascular structures, including the internal iliac vessels, obturator bundle, and pelvic sidewall veins, were isolated and preserved. Nerve pathways, including the sacral plexus and hypogastric nerves, were carefully delineated. The recurrent mass was then mobilized and resected en bloc applying a no-touch isolation technique, minimizing direct manipulation of the tumor and reducing the risk of tumor cell dissemination. Haemostasis was achieved with selective vascular clamping and bipolar sealing devices as needed.

Results

The three-step technique was successfully implemented in patients with isolated pelvic recurrence of HGSOC. Complete gross resection was achieved, with preservation of vital structures and without major intraoperative vascular or neurologic complications. The use of CUSA significantly improved dissection in fibrotic and previously treated surgical fields. No intraoperative tumor rupture or peritoneal contamination were observed.

Conclusions

This approach demonstrates the safe and effective integration of CUSA technology with intraoperative ultrasound guidance and a no-touch en-bloc resection technique in the management of pelvic recurrence of HGSOC. It allows for high-precision, organ-sparing surgery even in anatomically challenging settings, offering a promising strategy to improve surgical outcomes in a highly complex patient population.

<https://player.vimeo.com/video/1091318763?autoplay=1>

Near Uterine Perforation by LNG-IUS: A Video-Based Description of Technical Strategies and Surgical Pearls

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Background

A retrospective study highlights the value of hysteroscopy, with occasional ultrasound or laparoscopic assistance, for accurate IUD localization and removal under direct vision, particularly in cases of broken or embedded fragments. Objective of this article is to present the management of two cases of IUD-related "near perforation," highlighting surgical techniques and the benefits of a combined minimally invasive approach.

Methods

Case 1: A 35-year-old nulligravida presented with abdominal pain and abnormal vaginal bleeding. A 52 mg levonorgestrel-releasing IUD had been inserted for menometrorrhagia. 2D and 3D ultrasound showed the IUD embedded in the right fundal myometrium with visible threads in the cavity. After outpatient hysteroscopy, a combined hysteroscopic-laparoscopic procedure was performed. A preliminary polypectomy improved visualization. The device, completely intramyometrial, could not be removed with grasping forceps, so the myometrial tract was enlarged using a bipolar electrode. Laparoscopic monitoring excluded serosal damage. To minimize perforation risk, 5 Fr mechanical scissors were used. The IUD was mobilized with a tenaculum and removed safely. No complications occurred.

Case 2: A 37-year-old multipara, also with abdominal pain and bleeding, had an identical IUD. Outpatient hysteroscopy revealed the device embedded in the posterior uterine wall. The tract was enlarged with a bipolar electrode and the IUD was extracted under direct vision. No perforation was observed.

Results

Both incarcerated IUDs were successfully removed without complications.

Conclusions

Incarcerated IUDs may require a tailored, image-guided approach. Preoperative ultrasound and hysteroscopy are crucial for localization and surgical planning. When embedded within the myometrium or near the serosa, a combined hysteroscopic-laparoscopic technique ensures safety and effectiveness. The use of miniaturized mechanical and electrosurgical instruments enables precise dissection and minimizes perforation risk. These cases illustrate how a minimally invasive, multidisciplinary strategy optimizes outcomes and preserves uterine integrity—an approach underrepresented in current multimedia literature.

<https://player.vimeo.com/video/1090271289?autoplay=1>

Clinical outcomes of vaginal natural orifice transluminal endoscopic surgery (vNOTES) in gynecology: a systematic review and meta-analysis

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Background

To critically evaluate the clinical outcomes of vaginal natural orifice transluminal endoscopic surgery (vNOTES) compared to conventional minimally invasive surgery (MIS), including multiport laparoscopy and laparoendoscopic single-site surgery (LESS), for the treatment of benign gynecological conditions.

Methods

A systematic review and meta-analysis were conducted according to PRISMA guidelines and registered on PROSPERO (CRD42025639454). A comprehensive search was performed in PubMed, Web of Science, and Scopus up to January 2025. Studies were included if they reported at least one perioperative or postoperative outcome in adult women undergoing hysterectomy or adnexal surgery for benign indications, comparing vNOTES with other MIS approaches. Eligible designs included randomized controlled trials (RCTs), cohort studies, and case-control studies. Outcomes analysed included conversion rates, intraoperative and postoperative complication rates, operative time, estimated blood loss (EBL), postoperative pain, and length of hospital stay. Meta-analyses were conducted using a random-effects model. The methodological quality of the included studies was independently assessed using validated tools. Heterogeneity was evaluated using the Cochrane's Q test and I^2 index.

Results

A total of 33 studies were included. vNOTES was associated with significantly lower rates of intraoperative complications (odds ratio [OR] = 0.51, 95% CI: 0.29–0.88; p = 0.016; I^2 = 0%) and postoperative complications (OR = 0.60, 95% CI: 0.38–0.95; p = 0.030; I^2 = 49.2%). Operative time was significantly shorter with vNOTES (mean difference [MD] = -24.53 minutes, 95% CI: -32.15 to -16.91; p < 0.0001), although heterogeneity was high (I^2 = 91.1%). No significant differences were observed in conversion rates (OR = 1.59, 95% CI: 0.66–3.83; p = 0.300; I^2 = 31.2%), EBL (MD = -14.02 mL, 95% CI: -34.13 to 6.10; p = 0.172; I^2 = 83.4%), or hospital stay (MD = 0.31 days, 95% CI: -1.99 to 2.60; p = 0.793; I^2 = 98.6%). Subgroup analyses revealed no significant differences between RCTs and observational studies for any outcome.

Conclusions

vNOTES appears to be a safe and effective alternative to conventional MIS for benign gynecological surgery, offering advantages in terms of reduced intraoperative and postoperative complications and

shorter operative time. However, findings regarding EBL, conversion rates, and hospital stay were not statistically significant. Further high-quality studies are needed to establish clearer indications, optimize patient selection, and address current limitations related to surgical expertise and training.

V-notes Left Extraperitoneal and Right Intraperitoneal Bulky Pelvic Lymph Node Dissection After Failure of The Sentinel Lymph Node Procedure

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Background

In this video, we present a bilateral bulky pelvic lymph node dissection performed extraperitoneal on the left side and intraperitoneally on the right side via the v-NOTES approach in a patient with endometrial cancer.

Methods

A 41-year-old female patient admitted with abnormal uterine bleeding. Endometrial biopsy revealed endometrioid carcinoma, FIGO grade 2. CT imaging showed suspicious bulky lymph nodes in the right axilla and pelvic region. A biopsy of the right axillary lymph node was reported as reactive. Based on these findings, the patient underwent v-NOTES hysterectomy, bilateral salpingo-oophorectomy, and bilateral sentinel lymph node dissection.

Results

Following ICG injection, a suspicious stained area was identified on the right side and sent for frozen section analysis. No ICG uptake was observed on the left; therefore, a retroperitoneal pelvic lymph node dissection was performed on the left side. While awaiting the frozen section result, the operation continued with the hysterectomy. No lymph node was identified in the frozen section, and the v-NOTES hysterectomy was completed. Therefore, an intraperitoneal right pelvic lymph node dissection was performed.

Conclusions

v-NOTES has recently gained popularity, especially for benign gynaecologic conditions. However, its application in oncologic surgery is increasingly being explored. The v-NOTES technique allows both intraperitoneal and extraperitoneal pelvic lymph node dissection in appropriately selected patients.

<https://player.vimeo.com/video/1085514565?autoplay=1>

Single-Port Robotic Surgery for Rectal Endometriosis: Less Invasive, More Cosmetic

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Background

The evolution of gynaecologic surgery has progressed from traditional open procedures to minimally invasive surgery (MIS), offering significant benefits in patient recovery and outcomes. Within MIS, two major approaches have emerged: reduced-port surgery, such as single-port techniques, which prioritize cosmetic outcomes and minimal invasiveness; and robotic surgery, which emphasizes surgical precision, ergonomics, and stability. Traditionally, these two approaches were considered mutually exclusive, requiring surgeons to choose one over the other. However, with recent advancements in surgical technology, the integration of both approaches has become possible—leading to the development of the da Vinci SP system. Although SP is expected to play a greater role in MIS, reports on its utility remain limited. Therefore, the aim of this video is to demonstrate the anatomical and technical features of complex intrapelvic procedures—specifically, nerve-sparing rectal discoid and segmental resection for rectal endometriosis—performed using the SP system.

Methods

A 25–30 mm vertical incision was made at the umbilicus to insert the SP access port, allowing placement of three articulating instruments and a camera. An additional assistant port was introduced in the lower quadrant. The surgical steps were completely identical to conventional multiport laparoscopic robotic surgery.

Results

The procedures were completed without complications, and the postoperative course was uneventful, with no cases of bladder or rectal dysfunction. Patients expressed high satisfaction with minimal postoperative pain and inconspicuous scarring. SP offered several advantages, including high-resolution 3D visualization, articulating instruments, and improved dexterity and range of motion. These features enabled precise dissection even in technically challenging cases, such as deep endometriosis. Moreover, the umbilical access port facilitated proximal bowel resection, specimen retrieval, and anvil placement.

Conclusions

SP is a technically safe and feasible approach for the surgical management of rectal endometriosis, offering excellent cosmetic and clinical outcomes. This advanced technology expands the potential of single-port laparoscopic surgery, especially in complex procedures.

<https://player.vimeo.com/video/1082084037?autoplay=1>

The Trans umbilical Laparoendoscopic Single-Site Extraperitoneal Approach for Para-Aortic Lymphadenectomy

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Background

To investigate the technical feasibility of trans umbilical laparoendoscopic single-site (TU-LESS) extraperitoneal approach for para-aortic lymphadenectomy. This novel approach effectively overcomes the limitations of surgical exposure of para-aortic lymph nodes in traditional laparoscopic procedures. Due to minimal intraperitoneal organ interference and ease of manipulation, this technique not only reduces the risk of intraoperative organ and vascular injury but also decreases the incidence of complications such as intra-abdominal infection and intestinal adhesions.

Methods

A longitudinal incision approximately 3 cm in length was made in the posterior peritoneum at the level of the umbilicus to serve as the access route for para-aortic lymphadenectomy. Subsequently, para-aortic lymph nodes were completely resected using a trans umbilical laparoendoscopic single-site (TU-LESS) approach.

Results

This operation lasted for 170 minutes. A total of 24 bilateral pelvic lymph nodes were resected, and 5 groups of paraaortic lymph nodes (28 nodes in total) were resected. The estimated blood loss was approximately 50 ml. Postoperative pathology revealed poorly differentiated endometrioid adenocarcinoma with deep myometrial invasion (>1/2 myometrial depth). No neoplastic involvement was identified in the lower uterine segment or bilateral parametria, and no lymph node metastasis was detected.

Conclusions

The trans umbilical laparoendoscopic single-site (TU-LESS) extraperitoneal approach for para-aortic lymphadenectomy overcomes the challenge of surgical exposure in traditional laparoscopic surgery. Due to the clear operative field, this approach reduces the risk of injury to intra-abdominal organs, blood vessels, and nerves during surgery. Additionally, minimal intestinal interference helps lower the incidence of postoperative complications such as abdominal adhesions and intestinal obstruction. This surgical procedure is characterized by minimal trauma and mild pain. When combined with the implementation of Enhanced Recovery After Surgery (ERAS), it can facilitate rapid recovery, reduce hospital stay, and lower medical costs.

<https://player.vimeo.com/video/1083930435?autoplay=1>

New Prospects for High-Intensity Focused Ultrasound Ablation in the Treatment of Uterine Arteriovenous Fistula Associated with Retained Products of Conception: A Retrospective Cohort Study

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Background

Uterine arteriovenous fistula (UAVF), characterized by abnormal arteriovenous connections, predominantly arises from retained products of conception after pregnancy-related events. This condition predisposes reproductive-age women to life-threatening haemorrhage and complicates fertility preservation.

Methods

This retrospective study included 49 reproductive-age UAVF patients with pregnancy history, divided into three groups: hysteroscopy alone (n=26), UAE combined with hysteroscopy (n=11), and HIFU monotherapy (n=12). Outcomes evaluated over 6 months included treatment success rate, intraoperative blood loss, hospitalization duration, and fertility-related complications (recurrent bleeding, adhesions, ovarian reserve decline).

Results

HIFU monotherapy achieved 100% success rate with minimal blood loss (median 20 mL vs. 85 mL in hysteroscopy and 50 mL in UAE-hysteroscopy) and shortest hospitalization (2.1 days vs. 4.5 and 3.8 days). At 6 months, the HIFU group exhibited significantly lower rates of abnormal bleeding (8.3% vs. 34.6% and 27.3%) and intrauterine adhesions (0% vs. 19.2% and 18.2%), with preserved ovarian function (AMH: 3.2 ± 0.8 ng/mL vs. 2.1 ± 0.6 and 2.4 ± 0.7 ng/mL).

Conclusions

For pregnancy-associated UAVF, HIFU offers a fertility-preserving advantage over conventional strategies by eliminating retained conception products non-invasively, minimizing uterine trauma, and preventing vascular compromise. These benefits position HIFU as a first-line option for UAVF patients with reproductive demands.

Real time neuromonitoring-guided laparoscopic sciatic and sacral nerve decompression: A novel technique to prevent foot drop and preserve sensorimotor function

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Background

: This study introduces a novel approach combining real-time neuromonitoring with laparoscopic dissection to achieve vascular decompression of the sciatic and sacral nerves to prevent foot drop and preserve sensorimotor function.

Methods

A 30-year-old patient diagnosed with lumbosacral plexus vascular entrapment, presenting with sciatica and chronic pelvic pain underwent laparoscopic nerve decompression with intraoperative neurophysiological monitoring (IONM)

IONM was conducted using a Nicolet Endeavor system, employing five modalities: spontaneous electromyography (EMG), transcranial motor-evoked potentials (TcMEP), somatosensory evoked potentials (SEP), direct nerve root stimulation, and bulbocavernosus reflex testing. Monitoring targeted the L5, S1, S2, S3, and S4 nerve roots, with recordings obtained before, during and after the procedure.

During laparoscopic exploration, a wide peritoneal incision was made between the external iliac vessels and the iliopsoas muscle using a LigaSure vessel-sealing device to access the iliolumbar fossa. Multiple abnormal vascular branches compressing the sciatic nerve and sacral nerve roots were coagulated and divided with LigaSure. Continuous free-running EMG monitoring was performed throughout the procedure to detect any spontaneous discharges indicating potential nerve irritation or injury. At the end of the surgery, the sciatic nerve and sacral nerve roots were successfully decompressed.

Results

Real-time neuromonitoring-guided laparoscopic decompression of the sciatic and sacral nerve roots did not result in significant alterations in transcranial motor evoked potentials, somatosensory evoked potentials (SEP), or bulbocavernosus reflex potentials in the operated extremity. The postoperative course was uneventful, with the patient demonstrating preserved motor and sensory function

Conclusions

This innovative laparoscopic technique, combined with intraoperative nerve monitoring (IONM) and electro neurostimulation, marks a significant step forward in pelvic nerve decompression surgery enhancing motor function assessment and minimizing nerve injury risks. Ongoing research will further clarify its clinical impact

<https://player.vimeo.com/video/1079108200?autoplay=1>

Hysteroscopic Ablation of Myomas: Correlation of Sonographic Findings with Procedural Outcomes.

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Background

Myolysis using thermal ablation techniques such as radiofrequency (RFA) and microwaves (MWA) is a minimally invasive treatment for symptomatic uterine fibroids that can be performed via several routes, including percutaneous, transvaginal and transcervical. Hysteroscopy is an innovative option to perform myolysis, especially for submucous myomas. However, procedural and clinical outcomes are variable and there is no consensus on which ablative technique to prefer. Fibroids characteristics including topography, dimensions, echogenicity and vascularity may affect myolysis results and differently in the two groups of procedures. Our aim is to investigate the correlation between fibroids characteristics assessed at ultrasound and procedural and clinical outcomes after hysteroscopic myolysis.

Methods

A prospective observational study is ongoing at Federico II University of Naples including women with submucous fibroids FIGO type 1 and 2 undergoing hysteroscopic myolysis by RFA or MWA for AUB. All patients are undergoing a transvaginal ultrasound prior to treatment, assessing fibroid size, echogenicity, vascularity and location according to a structured protocol. Outcomes ("treatment response") are: (i) clinical improvement, measured by means of a survey administered to patients at 1- and 3-months follow-up; (ii) sonographic improvement, measured in terms of shrinkage and vascularity reduction at 1- and 3-months follow-up. For patients undergoing additional hysteroscopic myomectomy after myolysis, the surgical benefits were assessed including consistency, cleavage plane, operative time and bleeding.

Results

Preliminary data suggest that RFA and MWA are equally effective on symptoms at 1- and 3-months follow-up. Smaller lesions, mixed echogenicity, low to moderate vascularity correlate with best response to treatment. However, highly vascularized myomas show greater sonographic improvement in the MWA group compared to the RFA group, possibly due to the different physical principles of the procedures.

Conclusions

Pre-treatment sonographic features can help predict the efficacy of hysteroscopic myolysis. Incorporating a standardized ultrasound evaluation allows for better patient selection, improving outcomes and procedural efficiency.

Pelvic Floor Structure Segmentation Using Magnetic Resonance Imaging in Pelvic Organ Prolapse

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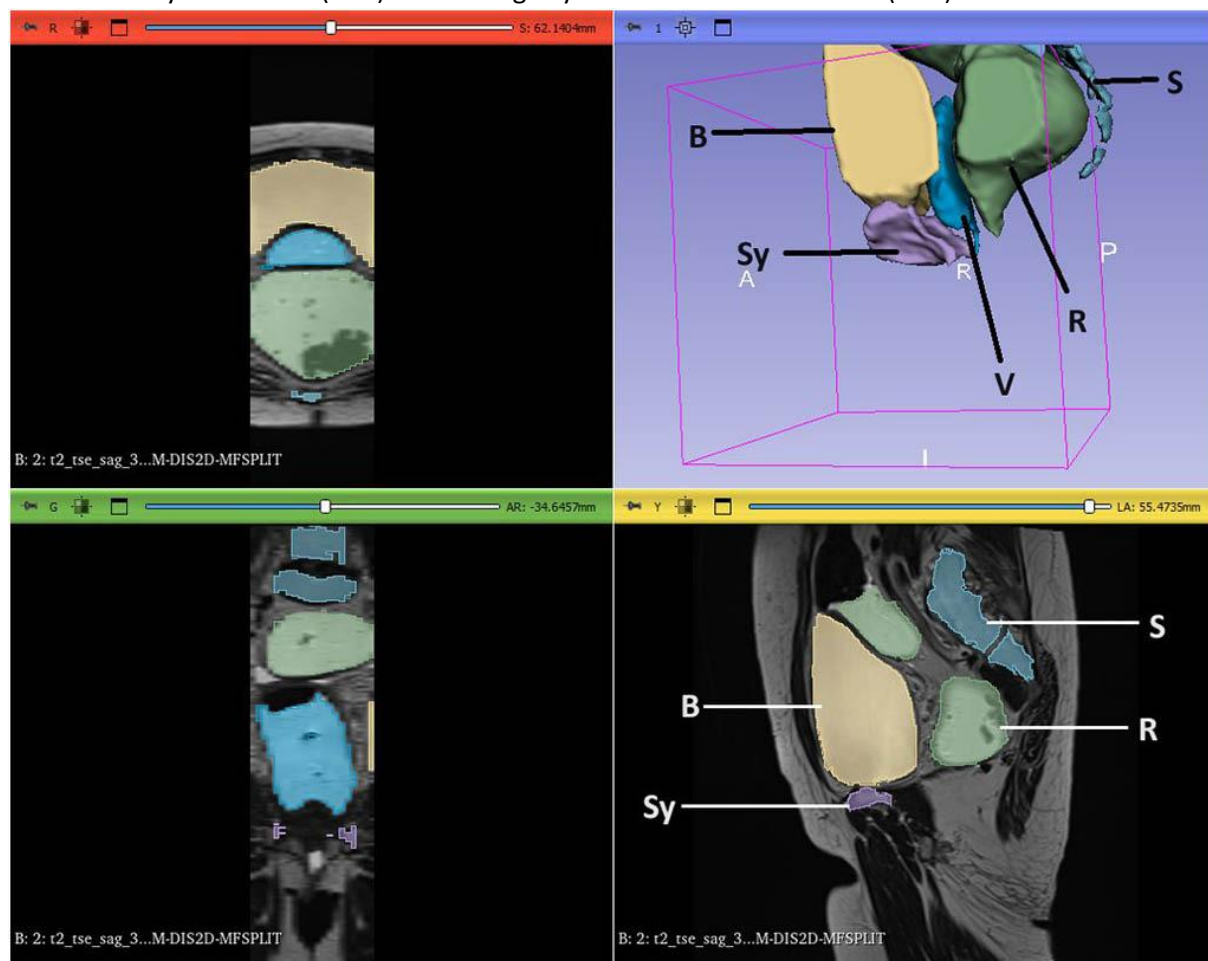
Background

Pelvic organ segmentation from MR images plays a crucial role in the diagnosis and management of disorders such as pelvic organ prolapse (POP). Manual segmentation is time-consuming and error-prone, highlighting the need for automated, reliable methods. In this project, we replicated and extended the study by Feng et al., which proposed a convolutional neural network (CNN)-based segmentation method using a U-Net architecture with an Xception encoder and a Multi-Resolution Feature Pyramid (MRFP) for improved feature representation.

Methods

We implemented a U-Net model with skip connections from an Xception-based encoder to a decoder, enhanced by an MRFP module that applied multi-scale convolutions with varying dilation rates to capture contextual information. The encoder employed depth wise separable convolutions, and dropout regularization was applied during training. We used a private pelvic MRI dataset consisting of 3D images from 36 female patients without prolapse. Annotations for bladder, vagina, rectum, and pubic symphysis were included. The dataset was split into 23 patients for training, 6 for validation, and 7 for testing. Data augmentation and weighted sampling were applied. Models were trained for 50 epochs with AdamW optimizer and an exponential learning rate decay. We compared performance using Dice Loss (DL), Cross Entropy (CE), and their combination, evaluating results with

Dice Similarity Coefficient (DSC) and Average Symmetric Surface Distance (ASD).



Results

The combined DL+CE loss achieved the best balance of performance, with our proposed model reaching an average DSC of 85.08 and ASD of 2.19. Compared to baseline models, the proposed model outperformed U-Net and DeepLabv3+ in DSC, though FCN-8s showed better ASD. Ablation studies revealed that the MRFP module alone improved U-Net's performance more than the full proposed model using both Xception and MRFP. Post-processing using a level-set method, as described in the original paper, did not improve results—likely due to implementation errors.

Conclusions

Our model successfully reproduced and improved upon the performance of previous architectures referenced in the original paper. Despite differences in datasets, the results confirmed the utility of skip connections and multi-resolution feature extraction. Notably, the ablation study highlighted the critical role of MRFP in enhancing segmentation accuracy. Future improvements may be possible with better tuning of the encoder and access to larger, diverse datasets, including patients with pelvic organ prolapse.

Management of enhanced myometrial vascularity after miscarriage and voluntary termination of pregnancy: a single- centre prospective observational study

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Background

Enhanced Myometrial Vascularity (EMV) is a rare condition characterized by high-flow communication between arteries and veins within the myometrium. It is often acquired after pregnancy, particularly miscarriages or voluntary terminations of pregnancy (VTP).

Due to its rarity, the pathological significance and optimal management of EMV remain debated. EMV may be asymptomatic or associated with mild bleeding. In these cases, spontaneous resolution is possible, and conservative management with progestogen therapy and expectant management (EM) may be appropriate.

However, EMV can cause acute anaemia due to severe, life-threatening haemorrhage, requiring emergency intervention with Uterine Artery Embolization (UAE) and hysteroscopic treatment.

The aim of our study is to report our single-centre experience in the diagnosis and management of EMV following miscarriage or VTP.

Methods

We performed a single-centre, prospective, observational analysis between September 2024 and May 2025. EMV were defined as myometrial vascular anomalies with a peak systolic velocity (PSV) ≥ 20 cm/sec at TVUS. We collected the subsequent clinical data: age, reproductive status, inciting event, time interval between inciting event and diagnosis, clinical presentation, type of treatment (EM vs UAE).

Results

743 patients were treated for miscarriage and VTP (respectively n.412, 55.4%; n.331, 44.5%). Between the miscarriage group, 94.7% (n.390) underwent medical treatment with misoprostol and 5.3% (n.22) were treated surgically. Between the VTP group 77.6% (n. 257) underwent medical treatment and 22.4% (n.74) were treated surgically.

Fifteen patients met the criteria for diagnosis of EMV (2.0%). Patients developed EMV: (n.9, 60%) after medical treatment for VTP, (n.3, 20%) after medical treatment for miscarriage, (n.2, 13.3%) after surgical treatment for VTP and (n.1, 6.7%) after surgical treatment for miscarriage.

Between EMV patients, (n.5, 33.3%) were asymptomatic, meanwhile (n.3, 20%) present with mild bleeding, (n.3, 20%) moderate bleeding and (n.4, 26.7%) with severe bleeding and anaemia.

One (6.7%) patient underwent emergency UAE. (n.13, 87.0%) were candidate to EM. One (6.7%) patient underwent elective UAE due to the refusal of EM. Between those who were candidate to EM, (n.2, 13.0%) patients underwent UAE due to persistence of EMV (n.1, 6.7%) or the onset of acute

bleeding (n.1, 6.7%). All 4 (26.7%) patients were treated hysteroscopically on the day after UAE, using 15Fr miniresectoscope, with no intraoperative complications.

Conclusions

Based on our single-centre experience, EMV appears to be an uncommon but potentially serious complication following miscarriage/VTP. When asymptomatic, the pathological significance of EMV remains unclear. Further large-scale prospective studies are needed to standardize diagnosis and management of this condition.

Diagnostic accuracy of the ultrasonographic features of uterosacral ligaments to identify their endometriosis involvement: a multicentric diagnostic study.

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Background

Uterosacral ligaments (USLs) represent the most frequent site of deep endometriosis. Surgery for USLs endometriosis is associated with a higher risk of ureteral and neurological complications, potentially leading to unpleasant bowel, urinary or sexual complaints. Therefore, accurate pre-operative diagnosis is pivotal for exhaustive counselling with the patient concerning potential iatrogenic morbidity and adequate surgical planning. The aim of this study was to assess the diagnostic accuracy of different ultrasonographic features of uterosacral ligaments affected by endometriosis.

Methods

This multicentric, observational, prospective diagnostic study was conducted at two tertiary care clinics (Human Reproduction Physiopathology, Azienda Ospedaliero-Universitaria di Bologna, Bologna, Italy, and Gynaecology Unit, Azienda Ospedaliero-Universitaria Senese, Siena, Italy). All consecutive symptomatic patients aged 18 to 50 years with an ultrasonographic diagnosis of endometriosis who underwent surgery between January and July 2023 were included. Preoperative ultrasonographic features of the uterosacral ligaments were compared between patients with histologically confirmed USL endometriosis and those without. Diagnostic accuracy metrics—including sensitivity, specificity, positive predictive value, negative predictive value, and area under the curve (AUC)—were calculated for the optimal anteroposterior diameter cut-off of the USLs (measured in millimetres), USLs echogenicity, peritoneal surface characteristics, tenderness on targeted probe pressure, and visualization of endometriotic lesions contiguous to the USLs.

Results

Eighty-five women were enrolled. The anteroposterior diameter of USLs affected by endometriosis was significantly greater than that of unaffected USLs [mean \pm SD: 5.0 \pm 2.5 mm vs. 3.3 \pm 1.6 mm, $p < .001$]. USLs with endometriosis more frequently exhibited hypoechoic or inhomogeneous echogenicity ($p < .001$), irregular peritoneal surfaces ($p < .001$), tenderness on targeted vaginal probe pressure ($p < .001$), and association with contiguous rectal endometriotic lesions ($p = 0.004$). The optimal USLs anteroposterior diameter cut-off for predicting USL endometriosis was 4.2 mm, yielding sensitivity, specificity and area under the curve (AUC) of 57.3%, 86.3%, and 0.72, respectively. When

this optimal diameter cut off was combined with other ultrasound features, the diagnostic accuracy was slightly higher (AUC = 0.75 for hypoechoic or inhomogeneous echogenicity, AUC = 0.75 for irregular surface, AUC = 0.76 for tenderness on targeted vaginal probe pressure and AUC = 0.75 for contiguous rectal endometriotic lesions).

Conclusions

Our findings suggest that the investigated ultrasound signs alone are inadequate diagnostic markers for endometriosis due to their low predictive values. However, when analysed collectively in multivariate models, they demonstrate moderate diagnostic accuracy. Specifically, the combination of an anteroposterior USL thickness > 4.2 mm with at least one of the aforementioned ultrasounds feature indicative of endometriosis may provide moderate accuracy in diagnosing USL involvement by endometriosis. Further studies with larger cohorts are warranted to validate these results and assess their reproducibility.

Adenomyosis: Should It Be a Warning Sign for the Presence of Pelvic Adhesions? An Analysis from the Adenomyosis Database

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Background

Uterine adenomyosis is associated with inflammatory processes that alter the pelvic tissue microenvironment. This study aimed to investigate the correlation between uterine adenomyosis and the presence of pelvic adhesions, with a focus on the role of transvaginal ultrasound (TVS) findings—specifically the sliding sign—as a potential indicator of altered pelvic anatomy (pelvic adhesions). The central question we sought to answer was: “Adenomyosis: should it be an alert for the presence of pelvic adhesions?” Our goal is to raise awareness among patients and gynecologists about this possible association, especially when planning surgical procedures.

Methods

A single-centre, retrospective observational study was conducted, enrolling 187 women aged 18–54 years who were not undergoing hormonal therapy. All patients underwent gynaecological examination and transvaginal ultrasound at the “DAI Materno-Infantile” unit of the Azienda Ospedaliera Universitaria “Federico II” in Naples between March 2020 and March 2025. TVS findings were analysed for the presence of adenomyosis and the sliding sign was assessed as a marker of uterine mobility and potential pelvic adhesions.

Results

Of the 187 patients, 68 (36%) had normal TVS findings, while 119 (64%) presented sonographic features consistent with adenomyosis. A regular myometrial echo structure was significantly associated with a positive sliding sign (62% vs. 38%; $p = 0.0558$). A significant association was observed between outer myometrial adenomyosis and a negative sliding sign (62% vs. 38%; $p = 0.0519$), particularly in diffuse cases (74% vs. 26%; $p = 0.0083$), but not in focal forms ($p = 0.7388$). Severe adenomyosis was significantly associated with a negative sliding sign (78% vs. 22%; $p = 0.0019$), as was anterior wall involvement (67% vs. 33%; $p = 0.0313$).

Conclusions

Ultrasound characterization of adenomyosis—considering its extent, location, and pattern—may provide clinically relevant information regarding the likelihood of pelvic adhesions. Diffuse outer myometrial involvement, severe adenomyosis, and anterior wall localization were all significantly associated with a negative sliding sign, suggesting reduced uterine mobility. These findings support the use of TVS as a non-invasive tool to alert clinicians to possible pelvic adhesions in patients with

adenomyosis, particularly in the context of preoperative planning.

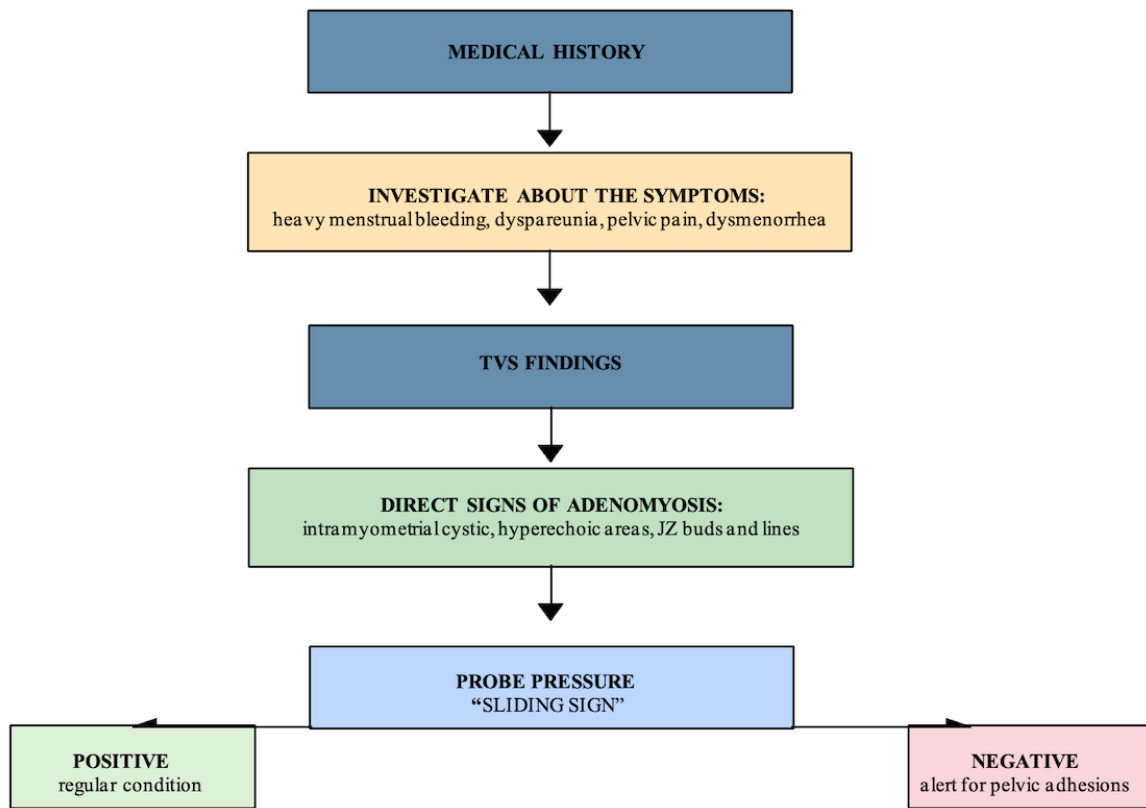


Table 1. Timeframe and management pathway for patients with adenomyosis and suspected pelvic adhesions.

Ileocecal endometriosis: the truth behind bowel occlusion

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Background

Infiltrating endometriosis affecting the terminal ileum accounts for 1–7% of women with bowel endometriosis, and in most cases, it is associated with other bowel lesions; an exclusive involvement of the ileocecal region is rare.

Methods

A 48-year-old woman was referred to our gynaecological department following admission for bowel occlusion. She reported chronic pelvic pain and dysmenorrhoea, without symptom relief from analgesics. Pelvic magnetic resonance imaging (MRI) revealed bilateral adnexal cysts consistent with endometriomas and a solid nodular lesion (37 mm) in the right iliac fossa, adherent to ileal loops and suspicious for deep infiltrating endometriosis causing bowel obstruction. A joint laparoscopic procedure was scheduled with a colorectal surgeon.

Results

Intraoperative findings revealed extensive pelvic adhesions with obliteration of the pouch of Douglas. Bilateral endometrioma drainage and adhesiolysis were performed, followed by ovarian suspension. Retraction of the ileocecal valve raised suspicion of deep ileal infiltration. Mobilisation of the ileocecal segment was achieved, and the mesocolon was divided with an energy sealing device until healthy ascending colon was reached. Adhesions between the bowel and omentum were lysed, and the ascending colon was detached from the lateral wall. An 8 cm ileocecal resection was performed using a 60 mm linear stapler, followed by a side-to-side functional ileocolic anastomosis. The remaining procedure included opening of the rectovaginal space and excision of pelvic endometriotic lesions involving the uterosacral ligaments and the vesicouterine peritoneum, along with removal of endometrioma pseudocapsules. Surgical time was 100 minutes. The patient was discharged on postoperative day 8, asymptomatic and without complications.

Conclusions

Although rare, terminal ileum endometriosis should be considered in reproductive-age women presenting with obstructive bowel symptoms. A multidisciplinary surgical approach is essential in such cases. Complete exploration of the peritoneal cavity is recommended to ensure the excision of all endometriotic foci.

<https://player.vimeo.com/video/1090228515?autoplay=1>

Beyond the Scalpel: Reimagining Chronic Pelvic Pain Management Through a Multidisciplinary Programme at North Bristol NHS Trust

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Background

Surgery, while essential for some conditions underlying Chronic Pelvic Pain (CPP), is not a cure-all. Many patients continue to experience debilitating pain post-operatively or are not suitable surgical candidates at all. Considering the complex, multifactorial nature of CPP, often involving central sensitisation, psychological distress, and pelvic floor dysfunction, there is a pressing need to rethink conventional models of care. This project aimed to design, implement, and evaluate a pelvic pain-specific Pain Management Programme (PPMP) to support individuals for whom surgical or medical treatments alone are insufficient.

Methods

Recognising the limitations of generic pain management approaches and the need for a more nuanced model, North Bristol NHS Trust developed the first tailored PPMP in Southwest England. A multidisciplinary team - including a Clinical Psychologist, Pelvic Health Physiotherapist, Occupational Therapist, Clinical Nurse Specialist, Nutritionist, Consultant Gynaecologist, and Psychosexual Medicine-trained doctor - delivered a 12-week group-based face-to-face programme. This included weekly sessions, individual reviews, targeted physiotherapy, and a 3-month follow-up. Participants (assigned female at birth) with persistent CPP and significant quality of life impact were screened for readiness and suitability. Outcomes were measured using psychometric questionnaires pre-, post-programme, and at 3-months, applying Minimal Clinically Important Differences (MCID) and Reliable Change Indices (RCI). Qualitative feedback was gathered via interviews and focus groups.

Results

Thirty-three participants (aged 21-59, mean age 37) completed four programme cycles. Diagnoses included endometriosis, adenomyosis, bladder pain syndrome, vulvodynia, and other persistent pelvic pain causing conditions. Most individuals had a history of surgical intervention. Of the 27 with matched pre- and post-programme data, ≥44% achieved clinically meaningful improvements across all variables. The most significant gains were seen in pain catastrophising (81%), self-efficacy (70%), depression (74%), and quality of life (74%). At 3-month follow-up, improvements were sustained and enhanced in several domains, notably self-efficacy (82%), pain catastrophising (73%), and patient activation (73%). The biggest drop was seen in depression (70% to 45%), prompting adaptations to facilitate peer connection post programme. Qualitative data underscored reduced isolation, enhanced validation, improved relationships, and increased empowerment among participants. The programme continues to run biannually, and data presented at congress will include outcomes from further cohorts.

Conclusions

This study reinforces that surgical or medical interventions alone cannot meet the complex needs of many people living with CPP. The North Bristol PPMP offers a replicable, clinically effective model that empowers patients through behaviour change, psychological support, and physiotherapy. This holistic, multidisciplinary approach is essential to modern pelvic pain care and should be integrated into broader service models to ensure patients receive comprehensive, person-centred support.

Deep endometriosis: laparoscopic parametrectomy, left ureteral reimplantation and segmental bowel resection.

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Background

Incidental finding during a routine evaluation in a 24-year-old asymptomatic female revealed left-sided hydronephrosis, for which placement of a double J stent was required. The patient was diagnosed with deep infiltrating endometriosis involving three pelvic compartments (anterior, lateral, and posterior), confirmed by imaging and clinical evaluation. A multidisciplinary surgical approach was indicated to achieve complete excision of endometriotic lesions and restore organ function.

Methods

Multidisciplinary laparoscopic approach for deep infiltrating endometriosis involving three compartments (anterior, lateral, and posterior). Intraoperative findings confirmed the presence of deep endometriotic nodules involving the left parametrium, the ureter, and the rectovaginal septum. Left parametrectomy was performed, followed by dissection and resection of the affected segment of the left ureter. Ureteral reimplantation was carried out successfully. Segmental resection of the affected portion of the bowel was performed, and an end-to-end anastomosis was completed using a circular stapler. The procedure was completed without intraoperative complications.

Results

The postoperative course was satisfactory, and the patient was discharged from the hospital ward on the 6th day.

Conclusions

Deep infiltrating endometriosis can present with atypical and silent findings, such as asymptomatic hydronephrosis. A multidisciplinary laparoscopic approach and an experienced team are essential for the effective management of complex endometriosis involving multiple pelvic compartments.

<https://player.vimeo.com/video/1085792136?autoplay=1>

The role of Indocyanine green (ICG) injection for precise deep endometriosis excision

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Background

Endometriosis is a complex disease that may result in retroperitoneal nodule with variable amount of fibrosis. The general strategy in surgery implies a wide dissection followed by the nodule resection guided by direct visualization and transvaginal palpation based on personal experience implying a risk of incomplete resection. Considering the high risk of recurrence for deep endometriosis and that an incomplete surgery is the leading cause we present a video article to show the enhancing effect of ICG intravenously in detecting deep endometriosis lesions.

Methods

We present two cases. The first one involving a 37-year-old female patient diagnosed with bilateral endometriomas, deep endometriosis, bladder, and tubal endometriosis, adenomyosis and infertility. The second one involving a 41-year-old female patient diagnosed with bilateral endometriomas, deep endometriosis and adenomyosis resistant to medical treatment. They were both managed surgically.

Results

Before the beginning of the surgery, we injected intraureteral ICG via cystoscopy using a 6 fr access, to have a direct visualization of the ureters in laparoscopy without the dissection. During the surgery, we then injected intravenous ICG. We used a 0.2 mg/kg cc of ICG diluted in 10 ml of saline solution for both the intraureteral and intravenous routes. Near-infrared imaging was performed using an infrared system. During our series, we found that endometriotic lesions picked up ICG with a variable distribution over time. We noted that we have a faster detection of the more vascularized lesions, while those that are more fibrotic or dated become highlighted by the ICG later. We started the resection immediately after the intravenous injection, then we come over to see what is left after 20, 30, 40 and 50 minutes.

Conclusions

The use of ICG can be a valid tool to identify deep endometriosis lesions very precisely in laparoscopy, however we need to standardize the timing that passes between the injection and the resection although 40 minutes seems to be a reasonable time.

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A Systematic Approach For Pudendal Nerve Endometriosis

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Background

Pudendal neuralgia is an uncommon yet debilitating cause of chronic pelvic pain, particularly in young women. It may present with clitoral pain, dysuria, or discomfort while sitting, and can be associated with deep infiltrating endometriosis (DIE), even in the absence of overt imaging findings.

Methods

A 24-year-old nulliparous woman presented with severe clitoral pain, pain while sitting, and urinary hesitancy. On rectal examination, left-sided pelvic tenderness was noted, while transabdominal ultrasound showed normal uterus and adnexa. Due to persistent symptoms and clinical suspicion of deep infiltrating endometriosis with pudendal nerve entrapment, diagnostic laparoscopy and pudendal nerve decompression was performed.

Results

Intraoperatively, prominent varicose veins were visualized near the sacrouterine ligament. Following peritoneal dissection in the left pelvic sidewall, the obturator nerve, arcus tendineus, and pudendal nerve were identified. An aberrant muscle fibre compressing the pudendal nerve was noted and carefully excised. Alcock's canal was decompressed, and the sacrospinous ligament was resected to fully free the nerve. Haemostasis was achieved, and the procedure was completed without complications.

Conclusions

This case highlights the potential role of laparoscopic pudendal nerve decompression in managing chronic pelvic pain and clitoral neuralgia in select patients. Even in the absence of radiologic evidence, surgical exploration may reveal compressive pathology. Resection of the sacrospinous ligament and decompression of Alcock's canal can be effective in relieving symptoms associated with pudendal nerve entrapment.

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How do large endometriomas respond to medical treatment with dienogest?

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Background

To evaluate the long-term efficacy of dienogest in managing large ovarian endometriomas (>5 cm) through transvaginal ultrasound (TVS), by assessing changes in endometrioma volume, maximum diameter, and any modifications in the #Enzian O compartment over time.

Methods

This retrospective observational study included patients evaluated at our Gynecological Ultrasound Unit with a typical TVS appearance of at least one ovarian endometrioma >5 cm, accompanied by characteristic endometriosis-related symptoms (dysmenorrhea, dyspareunia, dyschezia and dysuria). All patients were treated with oral dienogest 2 mg daily for up to 36 months. Endometrioma size was measured in three orthogonal planes, and volume was calculated using the prolate ellipsoid formula. Ultrasound assessments were performed at 6, 12, 24, and 36 months. The #Enzian classification was used to stage lesions in the O compartment and to describe any associated deep infiltrating endometriosis (DIE).

Results

A total of 46 patients with endometriomas >5 cm and up to 36 months of follow-up were included. The mean age was 27.3. At 6 months, endometrioma volume decreased by 64.8%, and maximum diameter by 33.4%, representing the most significant reduction during the treatment period. Between 6 and 12 months, the decline continued more gradually, with an additional 15.7% reduction in volume and 13% in diameter. This trend persisted moderately, reaching an overall reduction of 92.1% in volume and 65.3% in diameter by 36 months. A similar pattern was seen in the ovarian #Enzian score: 87.5% of endometriomas initially classified as O3 (>7 cm) were down staged to O2 at 6 months. Among those classified as O2 (3–7 cm), 34.2% were down staged in the same period. While the rate of downstaging slowed after 6 months, it continued steadily, reaching a cumulative reduction of 88.2% by 36 months. By the end of follow-up, 52.2% of endometriomas measured less than 3 cm in diameter, corresponding to an O1 classification.

Conclusions

Dienogest proves to be a highly effective treatment for large ovarian endometriomas, leading to significant and sustained reductions in cyst volume and diameter, along with progressive downstaging of the ovarian #Enzian score. While the most marked response occurs within the first 6 months, lesion regression continues more gradually over time, maintaining long-term therapeutic benefit. Prolonged progestin therapy represents a valuable non-invasive alternative to surgery, particularly for patients seeking ovarian preservation or at high surgical risk. These findings support the use of dienogest as a frontline conservative option in the management of large endometriomas.

Congenital uterine malformations and endometriosis: prevalence and correlation between ESGE/ESHRE classes and #ENZIAN compartments

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Background

The aim of the study is to assess the percentage of pelvic endometriosis/adenomyosis in patients with congenital uterine malformations according to the ESHRE/ESGE classification. Furthermore, to correlate, in presence of endometriosis, the class of uterine malformation to the different #Enzian compartments.

Methods

In our Ultrasound Gynecological Unit, between January 2018 and December 2024, a total of 285 congenital uterine malformations were diagnosed by transvaginal sonography (TVS), according to the ESHRE/ESGE classification. Each patient underwent a detailed 2D and 3D TVS examination to classify, based on appearance and measurements on the 3D uterine coronal section, the type of uterine anomaly and to detect direct TVS signs of endometriosis and adenomyosis according to the IDEA and MUSA studies. Presence of endometriosis was further classified using the #Enzian classification into different compartments (O, FA, A, B, C) and compared to the type of uterine anomaly.

Results

Among this cohort, 41 patients (14.4%) presented a dysmorphic uterus (U1), 190 (66.7%) had a septate uterus (U2), 21 (7.4%) had a bicornuate uterus (U3), 31 (10.9%) presented a hemi-uterus (U4), and 2 (0.7%) had an aplastic uterus (U5). Of the 285 patients, 110 (38.6%) showed at least one direct ultrasound sign of endometriosis or adenomyosis. Among those diagnosed with endometriosis, the majority were found to have a septate uterus (U2, 72.7%). Transvaginal sonography (TVS) identified endometriosis in 80 out of 190 U2 cases (42.1%), 19 of 41 U1 cases (46.3%), 3 of 21 U3 cases (14.3%), and 8 of 31 U4 cases (25.3%). No cases were reported among the U5 group. When correlating individual #ENZIAN compartments with the different ESHRE malformation categories, the O compartment was significantly more affected in U2 compared to U4 ($p = 0.04$). Conversely, adenomyosis (FA) was more common in the U4 group than in U2 ($p = 0.02$). Deep infiltrating endometriosis (DIE) was also more frequent in U2 (92.5%) than in U1 (57.9%) and U4 (25%). Notably, the B compartment was more involved in U2 (65%) than in U1 (21.1%). Meanwhile, the U3 group showed a higher involvement of compartment A compared to U2 (66.7% vs. 17.5%).

Conclusions

This study identifies an association between congenital uterine malformations and pelvic endometriosis/adenomyosis in 38.6% of cases. Septate uterus (U2) is most strongly associated with endometriosis, particularly with deep infiltrating endometriosis (DIE) involving compartment B. In the U3 group, greater involvement was observed in compartment A, while in the U4 group, the FA

compartment appears to be the most frequently affected. The presence of certain types of Müllerian anomalies may contribute to the pathogenesis of endometriotic lesions, likely due to abnormal uterine contractions. These findings further support the retrograde menstruation theory as a contributing mechanism in the development of endometriosis.

Age-related differences in endometriosis compartments classified by #Enzian classification through transvaginal ultrasound (TVS)

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Background

The #Enzian classification represents a standardized system for describing endometriotic lesions during surgery. Its application is well validated for correlating ultrasound with surgical findings. This study aimed to evaluate, in patients with endometriosis, without any prior surgery and hormonal therapy, age-related differences in compartment involvement and symptoms of endometriosis using #Enzian classification.

Methods

Patients evaluated at our ultrasound gynaecological unit with sonographic signs of endometriosis, without prior surgery and not undergoing hormonal therapy, were staged using the #Enzian classification (compartments A, B, C, O, T, FA, FB, FI, FU, FO). Participants were stratified into four groups according to their age (12-20, 21-30, 31-40 and 41-55 years). Statistical analysis compared the distribution of endometriosis across compartments and the prevalence of symptoms -dysmenorrhea, dyspareunia, dyschezia, dysuria, heavy menstrual bleeding (HMB) and intestinal symptoms- between the age groups.

Results

A total of 223 patients were enrolled, with a mean age of 29.3 ± 10.0 years. 74 women were aged 12-20, 40 aged 21-30, 74 aged 31-40 and 35 aged 41-55. The most frequently involved compartment was the B left in the 12-20 (51%), 21-30 (70%) and 31-40 (64.9%) groups. However, this compartment didn't show significant differences among the age groups. In contrast, the 41-55 group showed a higher prevalence of adenomyosis and compartment T (68.6%), particularly on the left side. A significant progressive increase was observed in the involvement of compartment A from the 12-20 group to the 31-40 group (5.4% vs 47%, $p < 0.0001$). Similarly, involvement of compartment C and T (both left and right) increased markedly with age, from 9.4% in the 12-20 group to 45.7%, in the 41-55 groups ($p < 0.0001$), especially for C3 lesions. The prevalence of adenomyosis also rose significantly with age (from 47.3% to 68.6%, $p = 0.03$). A progressive decrease in the visual analogue scale (VAS) score for dysmenorrhea and dyschezia was noted with increasing age, whereas no significant differences were found among age groups in the VAS score for dyspareunia, dysuria or the presence of intestinal symptoms. Notably, HMB was reported more frequently by younger patients compared to older ones.

Conclusions

The #Enzian classification proves to be a valuable tool for identifying age-related differences in the assessment of pelvic endometriosis by TVS. A progressive involvement of compartments A, C, T, and FA is observed with increasing age, whereas compartment B shows a stable pattern of involvement across all age groups. A detailed evaluation of the #Enzian compartments involved associated with

symptoms may support clinicians in tailoring optimal management strategies according to the patient's age group.

Feasibility, safety and outcome of single-port robotic hysterectomy: a case series.

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Background

Minimally invasive gynaecological surgery (MIGS) is continuously developing techniques and technologies to maximise surgical efficiency and outcomes. Among other options, reducing the number of ports to access the abdominal cavity is a strategy to reduce the invasiveness of the procedure. devices were introduced for single-port robotic surgery (e.g. Da Vinci SP® system, Intuitive Surgical System, 2018), potentially overcoming the technical shortcomings of MPS to single-port use (conflicts between instruments and camera and instruments). Hysterectomy is one of the most common procedures in gynaecology and is nowadays most often performed with minimally invasive approach, including laparoscopy, v notes and robotic-assisted laparoscopy. The aim of this reports to investigate the efficiency and surgical outcomes of single port robotic hysterectomy (SPRH) for benign conditions by presenting five consecutive cases undergoing surgery according to a structured surgical plan performed by the same surgeon in a single centre.

Methods

Case series of SP robotic hysterectomy procedures conducted from November 2024 to January 2025 at a tertiary referral centre, University Hospitals Leuven, Leuven, Belgium. All patients were operated by the same surgeon according to a structured surgical protocol. The Da Vinci SP system (Intuitive) was used, with a single trans umbilical 3 cm access. Intraoperative characteristics included the surgical time (defined as time from skin incision to closure), estimated blood loss (EBL) and peri-operative complications (e.g., visceral injury), conversion from the initial intended route (including placement of extra trocars) and the need for peri-operative blood transfusions. Postoperative characteristics collected were length of hospital stay, [WF2] post-operative complications as noted per Clavien-Dindo classification (CD) and readmission within 6 weeks post-operatively, assessed at the standard of care post-operative consultation. Information was retrieved from the clinical reports as well as review of the surgical videos. Ethics Committee approval was obtained (S70301)

Results

Five patients with a mean age of 46 years and mean BMI of 29,44 kg/m² underwent a SP robotic hysterectomy. 3/5 patients had a history of C-section, while 4/5 had previous pelvic surgery. The indication for hysterectomy was abnormal uterine bleeding in 4/5 patients and cervical adenocarcinoma in situ (AIS). Anatomopathological examination confirmed benign diagnoses (myomas n=2/5; adenomyosis n=2/5; AIS n=1/5). The mean uterine volume was 199,8. Total mean operative time was less than 100 minutes. Mean procedural EBL was 146 ml. There were no peri-operative complications, no conversions and no blood transfusions. Patients were discharged within 24 hours. No patient had post-operative complications, including infections and/or dehiscence.

Conclusions

Single-port robotic hysterectomy appears to be a safe and feasible technique, offering the benefits of robotic-assisted surgery along with cosmetic advantages due to the single incision. However, its precise role compared to other surgical approaches requires further investigation in future studies.

Da vinci's single port. Tips & tricks

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Background

Gynecologic surgeons have to learn till five different approaches during their working life. Although robots are designed to make surgery easier, surgeons need to adapt to new technologies considering that different models of robot are available in the market. Da Vinci's Single Port system needs special surgical skills adaptation due to the flexibility of its arms.

Methods

We have edited a video to highlight the different opportunities

We are showing our initial experience in a tertiary university hospital, Hospital Sant Pau, in Barcelona with the new da vinci's single port platform. This video has the objective to highlight the different capabilities that this new system allows.

Results

The video shows how easy are the placement and docking of the robot in different places including gynecology oncology procedures and benign gynecology procedures. We have compared dissection movements between the Xi multiport system and the SP system in a case of Sentinel lymph node dissection in an endometrial cancer case. This system is especially useful in narrow places like when the clipping of the uterine arteries at its origin and we are showing that suture can be easily and properly performed in difficult cases of myomectomy.

Conclusions

Considering our initial experience, da vinci's single port platform, allows to perform most of the surgical techniques that can be done in a minimally invasive approach with the advantage of an abdominal incision smaller than 3 cm and the possibility to access 360° in the abdominal cavity.

<https://player.vimeo.com/video/1090275361?autoplay=1>

da vinci single port. Set-up

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Background

Robotic surgery has been developed widely in gynecology. Several platforms are available in the market and most of them offer a multiport approach. Surgical procedures should be standardized to offer a reproducible technique and a safer surgery to our patients. New technologies offer the challenge of performing an optimal technique while we need to adapt to this technology. We present our technical initial experience with the new da vinci's single port robot.

Methods

We are showing our initial experience in a tertiary university hospital, Hospital Sant Pau, in Barcelona with the new da vinci's single port platform. We are showing a step by step standardized approach for a simpler and optimal set-up of the robot.

Results

After our initial experience of more than 25 procedures in 2 months including gynecology oncology procedures and benign gynecology procedures, including hysterectomy and bilateral adnexectomy with sentinel lymph node dissection, extraperitoneal paraaortic lymphadenectomy, hysterectomies for benign conditions, adnexectomy and omentectomy in border-line tumours and myomectomy, we are showing how to organise for an optimal set-up of the robot.

Conclusions

Considering our initial experience, da vinci's single port platform, allows to perform most of the surgical techniques that can be done in a minimally invasive approach with the advantage of an abdominal incision smaller than 3 cm and the possibility to access 360° in the abdominal cavity.

<https://player.vimeo.com/video/1090265846?autoplay=1>

Robotic Transvaginal Natural Orifice Hysterectomy in A Patient with Uterus Enlarged To 16-Week Gestational Size: A Surgical Video Presentation

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Background

V-NOTES (transvaginal natural orifice transluminal endoscopic surgery) has been successfully applied in adnexal surgery, hysterectomy, sacrocolpopexy, and even lymphadenectomy for early-stage endometrial cancer. Reported outcomes include reduced postoperative pain, shorter hospital stays, and lower complication rates. Despite these advantages, the widespread adoption of V-NOTES has been limited, potentially due to the need for advanced single-port laparoscopic skills.

Integrating robotic technology into the V-NOTES approach may shorten the learning curve for surgeons without prior single-port surgery experience. Wristed robotic instruments offer enhanced precision for suturing and dissection. Combining the benefits of V-NOTES with the precision of robotic systems may improve the feasibility and ease of this technique. This video presentation aims to demonstrate the robotic V-NOTES hysterectomy technique.

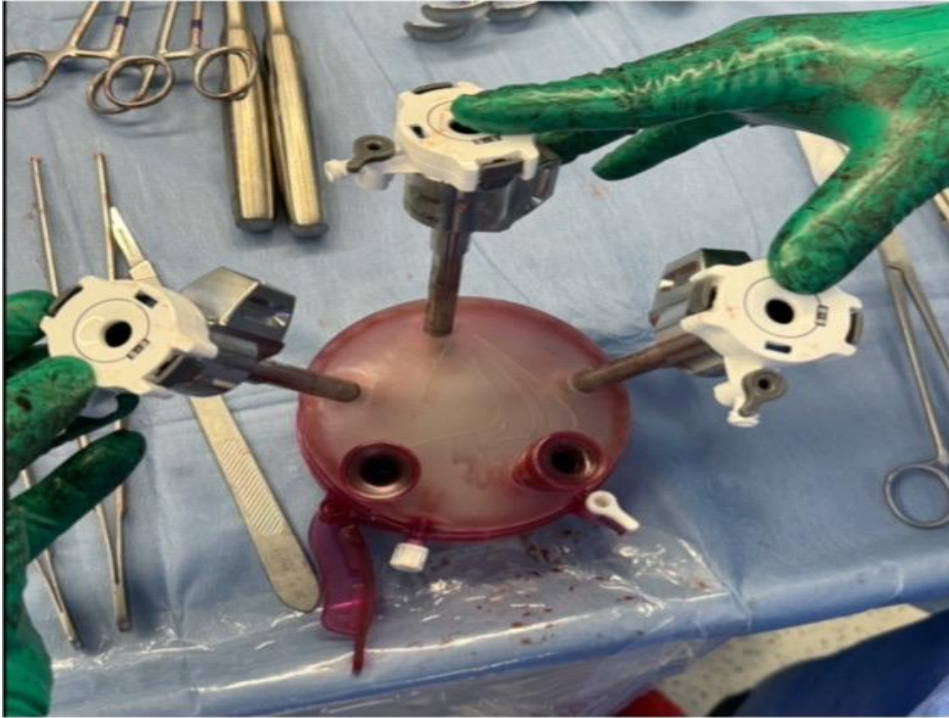
Methods

A 45-year-old premenopausal woman (gravida:1, parity:1, BMI:31) presented with abnormal uterine bleeding refractory to medical treatment. She underwent a robotic V-NOTES hysterectomy.

Surgical Steps:

- Circular cervical incision and transection of cardinal ligaments
- Opening of anterior and posterior colpotomies
- Insertion of the vaginal port with robotic trocars placed at the 10, 12, and 2 o'clock positions, and assistant trocars at the 5 and 7 o'clock positions
- Docking of the robotic system
- Visualization of the ureters followed by bipolar coagulation and transection of the uterosacral ligaments, uterine arteries, bilateral utero-ovarian ligaments, and round ligaments
- Removal of the uterus with bilateral fallopian tubes via the vaginal route

- Haemostasis confirmation and vaginal cuff closure



Results

No early or late complications were observed. The patient was discharged on postoperative day 1

Conclusions

With appropriate patient selection, robotic V-NOTES hysterectomy can enhance both patient and surgeon comfort while minimizing complication rates. However, extended anaesthesia duration and increased costs associated with robotic surgery highlight the importance of careful patient counselling and selection.

<https://player.vimeo.com/video/1090259162?autoplay=1>

Robotic-assisted surgery in gynecology - our experience in a tertiary centre in Portugal

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Background

Robotic-assisted gynaecological surgery has become a valuable alternative to conventional laparoscopy and open surgery, offering minimally invasive advantages while overcoming several limitations. Robotic platforms allow surgeons to perform complex procedures with enhanced precision, improved range of motion via articulated instruments, and superior visualization through 3D magnified imaging. These benefits result in reduced blood loss, fewer intraoperative complications, and shorter hospital stays, with comparable operative times and a relatively short learning curve.

We aim to describe the initial experience with robot-assisted gynaecological surgery using the Medtronic HUGO™ Robotic-Assisted Surgery (RAS) system at our tertiary care centre.

Methods

A retrospective observational cohort study including all patients who underwent robot-assisted gynaecological surgery at Unidade Local de Saúde Santo António between October 2023 and May 2025. Descriptive statistical analysis was performed.

Results

A total of 39 patients were included. The mean age was 50.6 years (range: 35–77), and mean BMI was 26.3. Regarding medical history, 14 patients (35.9%) had cardiovascular disease, 9 (23.1%) were obese, 9 (23.1%) had endometriosis, and 5 (12.8%) had respiratory disease. Previous abdominal surgery was noted in 20 patients (51.3%), including 11 who had undergone one (n = 9; 23.1%) or more (n = 2; 5.1%) caesarean sections.

The main indications were fibroids (n = 9; 23.1%), endometriosis (n = 9; 23.1%), endometrial hyperplasia (n = 9; 23.1%), adenomyosis (n = 8; 20.5%), adnexal mass (n = 4; 10.2%), urogenital prolapse (n = 3; 7.7%), and cervical intraepithelial neoplasia (n = 2; 5.1%).

Total hysterectomy was the most frequent procedure (n = 31; 79.5%), combined with salpingectomy in 16 cases (41.0%) and adnexectomy in 15 (38.5%). Other procedures included endometriosis excision (n = 6; 15.4%), subtotal hysterectomy with caesarean (n = 2; 5.1%), myomectomy (n = 1; 2.6%), and sacrocolpopexy (n = 1; 2.6%).

Mean operative time was 91 minutes, and postoperative hospital stay averaged 4.1 days (range: 2–7 days). One intraoperative complication (2.6%) occurred—iatrogenic rupture of an adnexal mass and difficult haemostasis at the vaginal vault. Postoperative complications included one vault hematoma (2.6%) managed conservatively and one surgical site infection (2.6%) treated with oral antibiotics. No urinary or gastrointestinal injuries occurred, and no readmissions were recorded.

Conclusions

This study demonstrates the safety and effectiveness of robotic-assisted gynaecological surgery using the Medtronic HUGO™ RAS system across various indications. The low complication rate and reduced operative time reflect the platform's safety profile and the surgical team's adaptability. Proper patient selection remains essential for optimizing outcomes, especially during early implementation. These findings support continued integration of robotic technology into gynaecologic surgical practice, particularly in tertiary centres managing complex cases. Further studies with larger cohorts and extended follow-up are required to validate these preliminary findings and assess long-term outcomes.

Robotic-assisted laparoscopic excision of a left ureteral endometriotic nodule causing hydronephrosis

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Background

Ureteral endometriosis is a rare but potentially serious form of deep infiltrating endometriosis (DIE) that can lead to silent and progressive renal function loss if left untreated. Early diagnosis and surgical management are critical to preserve renal function and alleviate symptoms.

Methods

A 34-year-old woman with a history of severe dysmenorrhea and progressive left flank pain was diagnosed with moderate left-sided hydronephrosis on imaging. Further evaluation revealed a fibrotic nodule encasing the distal left ureter, consistent with deep infiltrating endometriosis. Robotic-assisted laparoscopic surgery was planned for excision of the lesion. The pelvic sidewall was dissected to identify and isolate the left ureter. The fibrotic nodule was carefully excised, and ureterolysis was completed without the need for ureteral reimplantation.

Results

Intraoperatively, a dense fibrotic endometriotic lesion involving the left ureter was identified and successfully removed. No other significant endometriotic implants were found. The procedure was completed without complications. Postoperative recovery was uneventful, and follow-up imaging confirmed resolution of hydronephrosis with preserved renal function. Histopathology confirmed ureteral endometriosis.

Conclusions

Robotic-assisted laparoscopic excision of ureteral endometriotic nodules provides a precise and safe surgical option, particularly in anatomically complex cases. The enhanced visualization and dexterity of robotic instruments facilitate careful ureteral dissection and complete lesion removal. Early recognition and intervention are essential in preventing irreversible renal damage in patients with ureteral endometriosis.

<https://player.vimeo.com/video/1090216419?autoplay=1>

Robotic Hysterectomy in the Setting of Severe Vesicouterine Adhesions After Caesarean Section: A Stepwise Surgical Approach

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Background

To demonstrate a structured robotic approach to hysterectomy in a patient with dense vesicouterine adhesions following caesarean deliveries, emphasizing surgical strategy and bladder safety

Methods

A 50-year-old G2P2 woman with a history of two caesarean sections presented with postmenopausal bleeding. Endometrial biopsy revealed endometrial intraepithelial neoplasia. Sonographic findings included a normal-sized uterus with heterogeneous echogenicity consistent with adenomyosis and 12 mm endometrial thickness. CT showed no extrauterine disease. The patient underwent robotic total hysterectomy and bilateral salpingo-oophorectomy. Following abdominal entry, pelvic cytology was obtained. Dense adhesions were noted between the uterus, round ligaments, and anterior abdominal wall. On the left side, dissection began with lysis of sigmoid adhesions and entry into the retroperitoneum. The genitofemoral nerve, ureter, and infundibulopelvic ligament were identified and managed. The right side was approached similarly, including careful dissection of omental and bladder peritoneal adhesions. The most challenging area was the anterior compartment due to dense vesicouterine adhesions. To facilitate safe dissection, the bladder was filled with 300 mL of saline. A fibrotic band over the bladder was sharply incised bilaterally. The bladder and peritoneum were elevated en bloc, allowing sharp dissection into the obliterated vesicouterine space. Dissection continued into the vesicovaginal plane to the cervicovaginal junction.

Results

The uterus was removed vaginally via circumferential colpotomy. The vaginal cuff was closed with a running barbed suture. The procedure was completed without complications.

Conclusions

Robotic hysterectomy offers a safe and effective strategy for managing dense anterior adhesions. In patients with caesarean sections, careful and layered dissection of the vesicouterine space is essential to prevent bladder injury. The robotic platform enhances visualization and surgical precision, making it an ideal approach for such complex cases.

<https://player.vimeo.com/video/1090056354?autoplay=1>

The effect of High-intensity Theatre (HIT) lists using the Da-Vinci robotic system on theatre productivity in Gynaecology theatres: A tertiary centre prospective study

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Background

As healthcare systems worldwide grapple with limited resources and increasing demands for surgical services, optimising surgical efficiency is paramount for enhancing patient outcomes and resource utilisation. This prospective study aims to assess the impact of High Intensity Theatre (HIT) lists using the Da-Vinci robotic surgical system in comparison to traditional weekday lists and provides a step-by-step reproducible approach on key elements that contributed to its success.

Methods

We conducted a prospective study of utilising HIT lists for elective surgical cases performed at a tertiary hospital, Bristol, UK using the Da Vinci robotic system. All included cases in this study were performed by two surgeons to minimise variability. Key performance indicators (KPIs) including total operative time, theatre turnover times, surgical durations, conversion rates, length of stay, and complication rates were recorded. Data analysis was performed using Wilcoxon rank sum test and Pearson's Chi-squared test.

Results

A total of 225 patients who underwent robotic-assisted surgeries were included, of whom 75 patients underwent surgeries on HIT lists (over three weekends) and 150 patients underwent surgeries on a traditional weekday list between November 2023 and April 2025. Patient's demographics and surgical complexity scores were comparable between both groups. The introduction of HIT lists resulted in a significantly shorter turnover time of 6.75 (± 2.1) ($p < 0.05$) minutes, significantly shorter hospital stays with median of 9 hours ($p < 0.05$), while maintaining comparable complication rates and 30-day readmission rates using Clavien-Dindo classification ($p > 0.05$). There was no conversion to open surgery or return to theatres in the included patients.

Conclusions

The implementation of HIT lists using the Da Vinci robotic system significantly enhances theatre productivity, leading to an increased number of surgeries completed on the same theatre time while maintaining patient safety. This study outlines a reproducible protocol that includes preoperative planning, team training, and scheduling strategies to facilitate the adoption of this model in other hospitals.

Multinational Evaluation of Robotic-Assisted Hysterectomy with Adnexal Surgery using the Dexter System

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Background

Robotic-assisted hysterectomy is increasingly adopted in minimally invasive gynecology due to its ergonomic and technical advantages. However, widespread use remains limited by resource and infrastructure demands, and the need for dedicated robotic operating rooms. The Dexter surgical robot is, as a small, mobile, and open platform compatible with standard laparoscopic tower equipment and visualization systems, designed to adapt to various surgical environments. This study aimed to evaluate the short-term safety and clinical performance of the Dexter system in hysterectomy with adnexal surgery for benign indications.

Methods

This prospective, multinational, single-arm clinical study (ClinicalTrials.gov ID: NCT06473675) included 52 patients undergoing robotic-assisted hysterectomy with adnexal surgery using the Dexter system at four hospitals across Switzerland and France. Existing laparoscopic towers and endoscopic systems were employed in all centres. Primary endpoints were incidence of serious adverse events (Clavien-Dindo grade ≥ 3) within 42 days postoperatively, and procedural success, defined as completion of the surgery without conversion to laparoscopy or laparotomy. Secondary endpoints included intraoperative metrics (docking time, operative time, blood loss), postoperative recovery, and hospital stay.

Results

The mean patient age was 43.0 ± 11.7 years and mean BMI was 24.5 ± 4.3 kg/m². Total hysterectomy was performed in all cases; adnexal surgery included 42 salpingectomies (84%), 7 salpingo-oophorectomies (14%), and 1 oophorectomy (2%). In 11 cases, the procedure was completed using only 3 ports for the robotic arms; in the remaining cases, an additional trocar was used as needed for the assistant. No intraoperative complications or conversions occurred. The mean docking time was 3.8 ± 1.3 minutes, and mean total skin-to-skin operative time was 121.9 ± 42.7 minutes, including a console time of 77.2 ± 29.4 minutes. Estimated blood loss was low (mean 87.8 ± 93.8 mL), and no transfusions were required. Uterine weight ranged from 70–185 g (mean 151.1 ± 116.1 gram); a moderate positive correlation was observed between uterine weight and total operative time ($p < 0.001$). The mean hospital stay was 2.0 ± 0.9 days, with 2 patients discharged on the same day under the ERAS protocol. One Clavien-Dindo grade 3b complication occurred postoperatively—vaginal cuff bleeding from suture dehiscence on day 13—requiring re-operation. The event was not device-related and had fully resolved without sequelae by the 42-day follow-up.

Conclusions

The Dexter robotic system demonstrates strong clinical performance and safety for benign hysterectomy with adnexal surgery. Its efficient setup and operative times, and seamless integration with existing laparoscopic infrastructure make it a viable alternative to traditional robotic platforms. These results highlight its potential to enhance access to robotic surgery across a wide range of clinical environments and warrant further evaluation in larger, long-term studies.

Diagnostic Hysteroscopy In The Treatment Of Various Forms Of Infertility

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Background

In many countries around the world, infertility has been identified as a public health priority [1]. Approximately 75% of infertile couples have an identifiable cause.

Methods

The study material consists of a prospective analysis of the case histories of 28 patients who underwent diagnostic hysteroscopic surgeries at the Department of Obstetrics and Gynecology of the Azerbaijan Medical University. Indications for endovideoscopic interventions in 21.4% of cases were primary infertility, and in 38.5% of cases - secondary infertility. The age of the women ranged from 24 to 45 years. All patients underwent various examinations in Baku before admission to the clinic. Outpatient study data showed that all patients, regardless of the form of infertility, received complex anti-inflammatory treatment 2 or more times, hormonal treatment in 22.2% of cases, ovulation stimulation was prescribed in 29.3% of cases, hydroturbation courses (with various drug mixtures) were carried out in 9.2% of cases, and in vitro fertilization in 12% of cases. The average duration of the outpatient study was 2.3 ± 1.2 years. During hysteroscopy, the condition of the endometrium (colour, thickness, degree of expression of the vascular pattern, condition of the mouths of the fallopian tubes, synechiae and endometrial polyps, foci of adenomyosis and submucous nodes) and malformations (intrauterine septa) were assessed. Diagnostic laparoscopy was performed on days 5–8 of the menstrual cycle according to the generally accepted method with a set of endovideoscopic devices "karl storz" (Germany).

Results

Synechiae and narrowing of the lumen of the fallopian tubes of varying degrees and their complete obstruction, replacement of areas of focal hyperplasia with whitish thinned areas of the endometrium (cases of fibrosis) were assessed as chronic endometritis, which became the most frequently encountered pathology during hysteroscopy. Signs of this disease of a reliably high frequency were registered in Group I in 6 observations with intrauterine pathology; in the same way, signs of chronic endometritis of a high frequency were also identified in Group III, amounting to 13 observations. Hysteroscopic criteria for uterine endometriosis are point or slit-like single or multiple passages in the form of dark red eyes, changes in the relief of the uterine cavity, an uneven "rocky" picture. Signs of internal endometriosis were registered in group II in 4 cases. During hysteroscopy, endometrial polyps were noted as oval or irregularly shaped formations, similar in colour to the endometrium, protruding on its surface.

Conclusions

Research has shown that in women with reproductive dysfunction, several factors of infertility manifest themselves together, and identification of these factors is possible only by using diagnostic hysteroscopy and laparoscopy, as well as modern visual diagnostic methods.

Clinical Effectiveness of Mini Bipolar Hysteroscopic Resectoscope in the Management of Intrauterine Pathology in Reproductive-Age Girls

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Background

This study aims to assess the clinical effectiveness, safety, and feasibility of the mini bipolar hysteroscopic resectoscope in the treatment of intrauterine pathology in adolescent and young women of reproductive age. Given the anatomical and physiological characteristics of this group, there is a need for less invasive, organ-sparing techniques that minimize trauma while ensuring therapeutic efficacy.

Methods

A prospective clinical study was conducted involving 42 patients aged 15–25 years diagnosed with intrauterine pathologies such as endometrial polyps, submucosal myomas (FIGO type 0–1), and intrauterine adhesions. All procedures were performed using a mini bipolar hysteroscopic resectoscope (outer diameter ≤5 mm), applying a vaginoscopic "no-touch" approach in outpatient settings.

Intraoperative outcomes (operative time, bleeding, visibility), postoperative recovery (pain, return to daily activity), and recurrence rates were recorded. Follow-up was performed at 1, 3, and 6 months via clinical examination and imaging.

Results

The mini bipolar system ensured complete resection in 95.2% of cases during the first procedure. Cervical dilation was avoided in 88.1% of patients. No serious complications occurred. Pain was mild and transient in 9.5% of cases. The average operative time was 17.4 ± 5.2 minutes. Recurrence of pathology within 6 months occurred in 2 cases (4.8%).

Table 1. Clinical and Surgical Outcomes

Parameter	Value
Parameter	Value
Number of patients	42
Mean age (years)	20.8 ± 2.9
Complete resection (1st attempt)	40 (95.2%)
Cervical dilation required	5 (11.9%)

Parameter	Value
Parameter	Value
Mean operative time (minutes)	17.4 ± 5.2
Intraoperative complications	0
Postoperative mild pain	4 (9.5%)
Pathology recurrence (6 months)	2 (4.8%)

Conclusions

The mini bipolar hysteroscopic resectoscope is a safe, effective, and minimally invasive tool for the treatment of intrauterine pathologies in young women. Its small diameter and precise control allow for atraumatic intervention without the need for cervical dilation or general anaesthesia in most cases. The technique demonstrates high patient tolerability, rapid recovery, and low complication and recurrence rates—making it an optimal solution for reproductive-age patients, especially adolescents and nulliparous women.

Endometrial regenerative therapy in patients with thin endometrium: A prospective case series

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Background

Thin endometrium is a known adverse prognostic factor for embryo implantation and live birth in IVF cycles. Despite various therapeutic strategies, management remains challenging and no standardized treatment algorithm exists. This study aimed to evaluate the reproductive outcomes of patients with thin endometrium who underwent a combined regenerative and hormonal intrauterine therapy protocol.

Methods

This prospective observational study was conducted at a single IVF centre between January 2022 and January 2025. Eighteen patients with refractory thin endometrium (<7 mm) were included. Aetiologies were: unknown (n=8), T-shaped uterus (n=5), chronic endometrial infection (n=4), and unicornuate uterus (n=1). All patients underwent diagnostic 5-mm office hysteroscopy, followed by subendometrial platelet-rich plasma (PRP) injection and intrauterine MataRegen® hyaluronan gel application. Postoperatively, all patients received standardized hormonal therapy with oral estradiol valerate (12–18 mg/day for 28 days) and oral medroxyprogesterone acetate (10 mg/day during the final 7 days) to induce withdrawal bleeding. Endometrial response and pregnancy outcomes were recorded.

Results

All patients resumed menstruation following treatment. Four patients maintained an endometrial thickness <7 mm and did not proceed with embryo transfer. Among the 14 patients who underwent embryo transfer, 10 pregnancies were achieved. These included 6 live births, 1 ongoing pregnancy, 2 first-trimester miscarriages, and 1 intrauterine fetal demise at 24 weeks. The overall live birth rate among transferred cases was 42.8%, with a total pregnancy rate of 71.4%.

Conclusions

This study suggests that a multimodal regenerative approach—combining subendometrial PRP, hyaluronan gel, and tailored hormonal therapy—may support endometrial recovery and improve reproductive outcomes in patients with thin endometrium. The high clinical pregnancy and live birth rates observed in this cohort support the potential efficacy of this protocol. These findings underscore the need for further controlled trials to standardize treatment strategies and identify patients who may benefit most from regenerative intrauterine interventions.

Impact of postoperative intrauterine therapies on IVF outcomes in patients with Asherman's Syndrome

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Background

Asherman's syndrome (AS) is characterized by intrauterine adhesions (IUA) that result from trauma to the basal layer of the endometrium, frequently leading to amenorrhea, infertility, or pregnancy loss. In patients with severe AS, restoration of a functional endometrium is crucial prior to initiating assisted reproductive treatments. This study aimed to evaluate the effect of a standardized, multimodal postoperative intrauterine therapy protocol on endometrial recovery and IVF outcomes in patients with AS.

Methods

This prospective observational cohort study was conducted at a single IVF centre between January 2022 and January 2025. A total of 34 patients with severe IUA were treated using a standardized postoperative protocol consisting of hysteroscopic adhesiolysis followed by intrauterine platelet-rich plasma (PRP), MataRegen® hyaluronan gel, and 8F paediatric Foley catheter placement for 1–2 weeks. Following catheter removal, a copper intrauterine device (IUD) was inserted, and patients received oral estradiol valerate (12–18 mg/day for 28 days) and oral medroxyprogesterone acetate (10 mg/day for the last 7 days). Second-look office hysteroscopy was performed two months later. Patients with no residual adhesions, bilateral tubal ostia visualized, and endometrial thickness ≥ 7 mm were assigned to Group 1 (n=14), while those with persistent adhesions underwent repeated office hysteroscopies and were assigned to Group 2 (n=20). The study endpoints included restoration of menstruation, endometrial thickness ≥ 7 mm, and pregnancy outcomes following embryo transfer.

Results

All patients experienced recovery of menstruation. Despite severe baseline pathology, only 8 patients (4 per group) had persistent endometrial thickness < 7 mm and did not proceed to embryo transfer. A total of 10 pregnancies were achieved (29.4%). In Group 1, 5 pregnancies were observed (35.7%), resulting in 4 live births and 1 ongoing pregnancy. In Group 2, 5 pregnancies occurred (25.0%), including 2 live births, 1 ongoing pregnancy, 1 early miscarriage, and 1 biochemical pregnancy. Overall, 6 live births (17.6%) and 2 ongoing pregnancies were achieved among 34 patients with severe IUA.

Conclusions

A multimodal intrauterine treatment protocol combining mechanical, biological, and hormonal approaches led to favourable menstrual and reproductive outcomes in patients with severe AS. The complete resolution of menstrual disturbances and promising pregnancy results in both patient

groups support the integration of tailored intrauterine therapies into routine clinical practice for endometrial rehabilitation prior to IVF. Further large-scale studies are warranted.

<https://player.vimeo.com/video/1090227410?autoplay=1>

Hysteroscopic Resection of a Type 1 Submucosal Isthmic Fibroid: A Stepwise Approach

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Background

Submucosal fibroids, particularly those classified as Type 1 by the FIGO system, are known to contribute to abnormal uterine bleeding, infertility, and impaired endometrial receptivity. Hysteroscopic myomectomy is the gold standard for managing accessible submucosal fibroids. However, fibroids located at the uterine isthmus pose unique anatomical challenges due to proximity to the internal cervical os and thinner myometrial margins. This case demonstrates a safe and efficient hysteroscopic approach to resecting a Type 1 isthmic fibroid.

Methods

A 41-year-old nulliparous woman with a history of heavy menstrual bleeding underwent operative hysteroscopy for a 40 mm Type 1 submucosal fibroid located at the uterine isthmus. Under general anaesthesia, a 26 Fr continuous flow resectoscope with bipolar energy and normal saline distension was utilized. The fibroid was approached from its most protruding portion, and resection was performed in successive layers, taking care to maintain visualization and minimize fluid deficit.

Results

Complete resection of the fibroid was achieved in under 10 minutes, with minimal blood loss and excellent visualization throughout. There were no intraoperative complications. The endometrial cavity was inspected post-resection, confirming haemostasis and the absence of residual fibroid tissue. The patient was discharged the same day and reported significant improvement in menstrual symptoms.

Conclusions

Hysteroscopic management of Type 1 submucosal fibroids at the uterine isthmus is feasible and effective when performed with a methodical, layered resection technique. Attention to uterine orientation, haemostasis, and preservation of endometrial integrity is critical, particularly in anatomically narrow locations. This case underscores the safety and efficiency of hysteroscopic resection as a fertility-preserving, minimally invasive treatment option for symptomatic submucosal fibroids.

<https://player.vimeo.com/video/1090193838?autoplay=1>

Hysteroscopic Appearance of Endometrial Tuberculosis: A Case Series

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Background

To describe the spectrum of hysteroscopic findings in patients diagnosed with endometrial tuberculosis (ETB) through a case series and to review the intrauterine visual manifestations of this condition

Methods

A serial case report study of 4 patients was conducted in Cipto Mangun Kusumo Hospital by analysing medical records and hysteroscopic video findings of patients with a confirmed diagnosis of endometrial tuberculosis by histopathological examination of hysteroscopically guided endometrial biopsies. Visual characteristics of the uterine cavity, endometrium, and tubal ostia were recorded and identified

Results

All patient cases in this study presented with the same complaint, that is secondary amenorrhea. Varied hysteroscopic findings were observed in all these cases. For instance, cases 1 and 4 more prominently featured intrauterine adhesions and a thin endometrium, whereas case 2 presented with multiple micropolyps with foci of calcification. Meanwhile, case 3 showed a pale endometrium with no clear signs of vascularization. The effects of tuberculous infection on the cervical ostium were also evident in cases 1, 3, and 4; notably, case 4 exhibited recurrent stenosis. The use of hysteroscopy for diagnosing ETB is crucial, as it allows for visualization of the uterine cavity and performance of targeted biopsies. Hysteroscopic findings in cases of endometrial tuberculosis demonstrated wide variability. Commonly encountered appearances included: (1) Intrauterine adhesions (synechiae) of varying severity, ranging from flimsy and easily releasable to dense, fibrotic bands causing distortion or obliteration of the uterine cavity (Asherman's syndrome). (2) Tubal ostial changes, such as periosteal fibrosis, stenosis, or complete occlusion. (3) Small whitish or yellowish nodules (tubercles or caseous deposits) scattered on the endometrial surface. (4) Endometrial mucosal changes, including a hyperaemic appearance, edema, micropapillary ("strawberry") pattern, or conversely, a thin, pale, and atrophic endometrium. (5) Distortion of the uterine cavity shape due to chronic fibrosis. However, it was noted that in some cases, the uterine cavity could appear normal despite a confirmed diagnosis of ETB. Hysteroscopically guided biopsy from suspicious areas enhanced diagnostic yield.

Conclusions

The hysteroscopic appearance of endometrial tuberculosis is highly variable and often non-specific. Although findings such as intrauterine adhesions, caseous nodules, and tubal ostial abnormalities can raise suspicion, no single appearance is pathognomonic. Hysteroscopy plays a crucial role in the diagnosis of ETB, primarily due to its ability to allow direct visualization and targeted endometrial biopsy, which is essential for histopathological and microbiological confirmation. Awareness of these

varied hysteroscopic manifestations is important for gynaecologists, particularly in TB-endemic areas or in patients presenting with unexplained infertility and menstrual disorders.

<https://player.vimeo.com/video/1090777905?autoplay=1>

Adherent Pregnancy Tissue: The Role of Hysteroscopy in Diagnosis & Management

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Background

Retained products of conception (RPOC) is a recognised complication following miscarriage management. While most cases resolve with expectant or surgical treatment, persistent RPOC with increased vascularity may raise suspicion for more serious pathology, including arteriovenous malformation (AVM) or gestational trophoblastic disease. We present a complex case of persistent RPOC with abnormal vascular features mimicking AVM, which was ultimately diagnosed and treated with diagnostic hysteroscopy.

Methods

A young woman was diagnosed with a miscarriage at 7 weeks gestation. After counselling, she opted for manual vacuum aspiration (MVA) under local anaesthetic, which was performed without complication. At follow-up, she reported ongoing vaginal bleeding. Transvaginal ultrasound demonstrated an abnormal mixed echogenic mass within the endometrial cavity with rich vascularity on colour Doppler imaging, raising concern for invasive tissue, an AVM, or very vascular RPOC.

MRI of the pelvis was arranged to further evaluate the lesion, which suggested possible invasive or abnormally adherent tissue. Given the continued vascular appearance and persistent bleeding, the differential diagnosis included AVM. The patient was discussed in a multidisciplinary team setting, and diagnostic hysteroscopy was planned both for further evaluation and potential treatment.

Results

Hysteroscopy revealed a lesion within the left cornu which was consistent with adherent retained products of conception. The tissue was removed with a flexible suction and hydrodilation with hysteroscopy. Careful, intraoperative ultrasound was also performed. There was no evidence of AVM or abnormal vasculature involving the myometrium. Postoperatively, the patient had complete resolution of symptoms. Repeat ultrasound imaging showed no residual intrauterine tissue or vascular anomalies.

Conclusions

This case highlights the diagnostic challenge in managing patients with persistent RPOC from miscarriages. Hysteroscopy is becoming increasingly important and utilised in the field of Early Pregnancy. This case was unique as hysteroscopy served not just a diagnostic role, but a therapeutic role as well. A cautious, stepwise approach involving imaging, histopathology, and minimally invasive surgical techniques can avoid unnecessary embolisation or hysterectomy in women of reproductive age. Early multidisciplinary discussion is essential to guide appropriate management.

<https://player.vimeo.com/video/1085821891?autoplay=1>

Stratified Management of Retained Products of Conception: A Retrospective Analysis of Clinical Efficacy, Fertility Outcomes, and Patient Satisfaction

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Background

Retained products of conception (RPOC) following pregnancy termination pose significant risks to endometrial integrity and future fertility. Current management lacks consensus on optimizing minimally invasive strategies while balancing clinical efficacy and reproductive preservation. This study evaluates a stratified protocol incorporating residual tissue size, serum human chorionic gonadotropin (hCG) levels, and surgical technique-specific outcomes to guide evidence-based decision-making.

Methods

A single-centre retrospective cohort study (November 2023–October 2024) analysed 201 patients with first-trimester RPOC confirmed by transvaginal ultrasound. **Stratification criteria residual tissue size:** ≤ 2 cm (n=89) vs. >2 cm (n=112); **serum hCG:** ≤ 200 IU/L (n=83) vs. >200 IU/L (n=118).

Interventions comprised: **Medical therapy** (n=89): Estrogen-progestin combination with optional mifepristone; **Hysteroscopic resection** (n=112): Office-based procedures under low-pressure distension (<80 mmHg), utilizing cold grasper (n=42), monopolar electric loop (n=43), or mechanical morcellator (n=27).

Primary outcomes included complete expulsion rates and endometrial thickness (standardized mid-cycle ultrasound). Secondary outcomes encompassed intrauterine adhesion incidence (ASRM classification), 12-month conception rates (clinical/ β -hCG confirmation), and complications.

Statistical analysis employed chi-square tests for categorical variables and ANOVA with post-hoc Tukey tests for continuous measures ($\alpha=0.05$).

Results

Medical Management Efficacy: Residual ≤ 2 cm: 44.3% (27/61) achieved complete expulsion vs. 18.8% (5/28) in >2 cm group (RR=2.36, 95% CI 1.52-3.65; $p<0.001$). hCG ≤ 200 IU/L: 36.6% (15/41) success vs. 38.5% (17/44) in >200 IU/L group ($p=0.86$).

Hysteroscopic Outcomes

- **Adhesion rates:** Cold grasper: 9.5% (4/42); Electric loop: 7.0% (3/43); Morcellator: 0% (0/27) ($p=0.04$ for morcellator vs. combined conventional methods).
- **Conception rates:** Cold grasper: 52.4% (22/42); Electric loop: 60.5% (26/43); Morcellator: 70.4% (19/27) ($\chi^2=4.21$, $p=0.12$).

Endometrial Recovery Medical therapy demonstrated superior endometrial thickness (9.1 ± 1.2 mm) compared to hysteroscopic intervention (8.3 ± 1.5 mm; mean difference 0.8 mm, 95% CI 0.1-1.5; $p=0.04$).

Reproductive Outcomes Overall conception rates were comparable between medical (43.8%, 39/89) and surgical groups (56.2%, 63/112; $p=0.08$). All pregnancies achieved clinical viability by 12 weeks.

Safety No major intraoperative complications occurred. Mild adhesions developed in 5.8% (7/112) of hysteroscopic cases, all managed via outpatient heterolysis.

Conclusions

This stratified management protocol for retained products of conception effectively balances clinical efficacy with fertility preservation objectives. Medical therapy demonstrated superior endometrial integrity, making it the preferred initial approach for smaller residuals, while hysteroscopic intervention provided definitive management for larger remnants. Among surgical techniques, morcellation emerged as the most tissue-sparing modality, eliminating adhesion risks and potentially enhancing post-procedural fertility outcomes compared to conventional methods. The lack of correlation between serum hCG levels and therapeutic success challenges biomarker-driven decision paradigms, emphasizing the primacy of ultrasound-guided stratification. These findings support a patient-centred algorithm prioritizing minimally invasive strategies, with surgical technique selection critically influencing endometrial health and reproductive prognosis. The protocol aligns with contemporary goals of reducing unnecessary interventions while safeguarding future fertility.

A step-by-step description of the hysteroscopic injection of platelet-rich plasma (PRP) into the endo-myometrial junction for Asherman's Syndrome.

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Background

Asherman's syndrome causes intrauterine adhesions leading to infertility. Hysteroscopic adhesiolysis is standard treatment, but recurrence is common. PRP shows promise in improving endometrial regeneration; this study explores hysteroscopic PRP injection post-adhesiolysis.

Objective of this video article is to provide a detailed description of the management of a patient with Asherman's syndrome and to present a step-by-step account of the injection procedure at the endometrial-myometrial junction and its effects on endometrial trophism.

Methods

A 42-year-old patient diagnosed with Asherman's syndrome following uterine artery embolization for an intramural myoma was referred to our centre. The patient reported hypomenorrhea, and transvaginal ultrasound revealed an endometrial thickness of 2.57 mm. Using a 5 mm hysteroscope and miniaturized 5 Fr scissors, extensive adhesiolysis was performed until complete bilateral visualization of the tubal ostia was achieved. At the end of the procedure, 1 ml of PRP was injected into each uterine wall.

Four weeks after the injection, the patient was reassessed via ultrasound to evaluate endometrial thickness, as well as any changes in menstrual flow quantity and duration.

Results

At the ultrasound follow-up after 4 weeks, the endometrium appeared increased in thickness, and the patient reported menstrual flow.

Conclusions

The combination of hysteroscopic adhesiolysis and PRP injection could represent a novel approach to the treatment of Asherman's syndrome. In line with the conclusions of other authors, PRP injection improved endometrial thickness. Future perspectives will focus on determining its efficacy in terms of pregnancy rate and live birth rate.

<https://player.vimeo.com/video/1085497622?autoplay=1>

Improving Service Efficiency and Patient Experience in Postmenopausal Bleeding: Evaluation of a Postmenopausal Bleeding One-Stop “See and Treat” Outpatient Hysteroscopy Model

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Background

Post menopausal bleeding services in UHW:

The PMB one stop clinics:

- Clinical history by a health care professional
- TVS for endometrial thickness. (ET 4mm or more: offer vaginoscopy)
- If polyp found, patient referred under USC pathway to OPOC
- The clinic template is 6 patients (per consultant)

The PMB see and treat clinics:

- As above
- Patient will be offered TCRP during the same clinic visit
- The clinic template is 6 patients
-

Unscheduled bleeding on HRT – now on a separate pathway

Methods

Objectives:

To evaluate the effectiveness, acceptability, and patient satisfaction of a newly implemented one-stop “see and treat” hysteroscopy clinic for postmenopausal bleeding (PMB) compared to the conventional two-visit pathway.

Methods:

A combined retrospective and prospective service evaluation was conducted between August 1, 2024, and February 28, 2025. Women referred with PMB were assessed in outpatient clinics that offered same-day diagnostic hysteroscopy and treatment with transcervical resection of polyp (TCRP) when indicated. Data sources included clinic trackers, specific forms for prospective data collection, and patient letters. Patient satisfaction was evaluated through anonymous post-procedure questionnaires.

Results

A total of 147 patients were included. Of these, 22 (15%) underwent TCRP during the same visit, while 14 (10%) required a second visit due to patient preference, intolerance, or equipment unavailability. The mean time from clinic to diagnosis was reduced from 28.7 days (second visit pathway) to 17.1 days (one-stop clinic). The average duration to complete same-day TCRP was 51.4 minutes. Among 55 histology samples sent as urgent suspected cancer, 11 (7.5%) confirmed endometrial cancer or atypical hyperplasia. Patient satisfaction was high: 11 out of 15 respondents rated the service 10 out of 10, with recurring feedback praising the care provided by staff and the comfort of the experience.

Conclusions

The one-stop “see and treat” model for PMB improves diagnostic efficiency and is well accepted by patients. Recommendations include standardizing pre-visit information and targeting two TCRPs per clinic. Further studies are needed to assess provider perspectives and broader implementation.

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Free Communication

NOSES (Natural Orifice Specimen Extraction Surgery) for segmental colon resection at a deep infiltrative endometriosis case

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Background

Endometriosis is a chronic inflammatory condition where endometrial-like tissue grows outside the uterus. Deep infiltrative endometriosis is the most severe form, characterized by lesions that penetrate more than 5mm beneath the peritoneal surface. When DIE affects the bowel, most commonly the rectosigmoid colon, it can lead to debilitating symptoms such as severe pain (dyschezia, dyspareunia), altered bowel habits, and, in rare cases, bowel obstruction. Surgical excision is often the most effective treatment for symptomatic DIE, especially when medical management fails. Segmental colon resection is indicated for larger, deeply infiltrating lesions or multifocal disease that cannot be adequately treated with less extensive procedures like shaving or disc excision

Methods

The surgical management of deep infiltrative endometriosis (DIE) involving the rectosigmoid colon, when treated with segmental resection and Natural Orifice Specimen Extraction (NOSE), involves a series of meticulous steps performed under general anaesthesia. The goal is complete excision of endometriotic lesions with functional preservation, followed by specimen retrieval through a natural orifice to avoid an abdominal wall incision.

Results

In our case; 40 you. Female, G1P1, The patient with deep infiltrative endometriosis known for 2 years. Medical treatment for dysmenorrhea has been tried. Applied to our centre because of severe pain during defecation.

MRI images showed an approximately 3.5 cm endometriotic nodule at the sigmoid colon-rectum junction, involving the serosa to the mucosa, pulling both sacrouterine ligaments towards itself and involving the vaginal wall.

After this operation; the patient had no problems during follow-up, was discharged on the 5th postoperative day. Stated that she had no complaints and no pain during defecation at the 2nd and 4th postoperative month controls.

Conclusions

Natural Orifice Specimen Extraction (NOSE) surgery is ultra-minimally invasive technique that removes surgical specimens through existing body openings (like the anus or vagina), entirely avoiding external abdominal incisions.

This approach offers significant benefits including less pain, faster recovery, reduced complications like hernias, and superior cosmetic results

While technically demanding and requiring careful patient selection, NOSE represents a major leap forward in patient-centred surgical care

<https://player.vimeo.com/video/1089874779?autoplay=1>

Applications of Indocyanine Green Fluorescence in Benign Gynecologic Surgery: A Video-Based Clinical Review

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Background

Indocyanine Green (ICG) fluorescence has become a valuable tool in enhancing anatomical visualization during surgery. While widely used in oncology, its application in benign gynecology is gaining attention. This video-based presentation explores the clinical utility of ICG in complex benign gynaecologic surgeries, focusing on safety, precision, and surgical outcomes.

Methods

This review features surgical videos demonstrating ICG use in benign gynaecologic procedures. Key indications include ureteral identification in deep infiltrating endometriosis, assessment of bowel perfusion during resection and anastomosis, bladder visualization to avoid injury, and delineation of the endometrial cavity during myomectomy. All procedures were performed using laparoscopic systems with integrated near-infrared (NIR) imaging for real-time fluorescence guidance.

Results

ICG fluorescence enhanced intraoperative safety and anatomical clarity across all cases. Ureteral pathways were clearly visualized, and in some instances, ICG made ureteral dissection unnecessary, reducing operative time and tissue manipulation. Bowel perfusion was reliably assessed, aiding decision-making for resection and anastomosis. Bladder margins were well defined, especially in patients with adhesions or previous surgery. During myomectomy, ICG enabled precise visualization of the endometrial cavity, allowing for more targeted and conservative excision. No complications related to ICG use were reported.

Conclusions

ICG fluorescence is a safe and effective adjunct in minimally invasive surgery for benign gynaecologic conditions. It facilitates identification of critical structures and improves surgical confidence, especially in anatomically challenging cases such as deep endometriosis or reoperative fields. This video-based review highlights the growing role of ICG in enhancing outcomes in advanced benign gynaecologic surgery and supports its broader clinical adoption.

<https://player.vimeo.com/video/1088218069?autoplay=1>

Management of Huge Ovarian Cysts: The Dissect and Deflate (DaD) Technique.

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Background

Laparoscopic management of Huge (>10cm) ovarian cysts remains technically challenging due to limited intra-abdominal space, risk of rupture, and potential need for conversion to laparotomy. This video aims to demonstrate the Dissect and Deflate technique as a safe and effective minimally invasive approach to large benign cyst removal, using a case of acute ovarian torsion with a 27cm cyst in a postmenopausal patient as an example.

Methods

Our case revolves around a 50-year-old postmenopausal woman who presented with acute lower abdominal pain and was found to have a 27 cm ovarian serous cystadenoma on imaging. As there were clinical features of ovarian torsion, she was taken for emergency surgery. Given her age and the nature of the pathology, laparoscopic oophorectomy was planned. The procedure was performed using a standard laparoscopic setup with three small ports. After initial inspection, a controlled cyst decompression was performed using the Dissect and Deflate technique. A balloon-tip trocar was inserted directly into the cyst under vision to facilitate aspiration and reduce spillage. The cyst contents were evacuated in a controlled manner, allowing for safer mobilisation of the adnexa. This was performed with virtually any spillage. The ovary and remaining cyst wall were placed in an endobag and removed via the umbilical port without extension of the incision.

Results

The cyst was successfully decompressed and removed entirely via laparoscopic approach without any need for conversion to laparotomy or mini-laparotomy. Intraoperative spillage was minimised due to the secure seal provided by the balloon-tip trocar and controlled aspiration technique. The pathology confirmed a benign serous cystadenoma with no evidence of malignancy. The patient had an uncomplicated postoperative recovery and was discharged the following day.

Conclusions

The Dissect and Deflate technique allows for safe laparoscopic management of very large ovarian cysts in planned and emergency settings, such as torsion. Use of a balloon-tip trocar for controlled decompression offers superior containment compared to traditional aspiration methods and facilitates continued minimally invasive access without spillage or loss of working space. This case illustrates that, with appropriate technique, laparotomy can often be avoided—even in cases involving large adnexal masses in patients. This approach may support the broader adoption of laparoscopic surgery for large cysts and improve outcomes by reducing morbidity associated with open procedures.

<https://player.vimeo.com/video/1085842205?autoplay=1>

Modified Laparoscopic Vecchietti Vaginoplasty Using a Low-Cost Epidural Catheter System: Two Cases, Two Techniques

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Background

To describe a self-constructed, low-cost modification of laparoscopic Vecchietti vaginoplasty utilizing epidural catheters for combined traction and analgesia in two patients with Mayer-Rokitansky-Küster-Hauser (MRKH) syndrome, highlighting both intraperitoneal and retroperitoneal catheter placements.

Methods

This presentation involves human subjects and was approved by an institutional ethics committee. Two patients (aged 21 and 27 years) with MRKH syndrome, presenting with primary amenorrhea and complete vaginal agenesis, underwent the procedure. Imaging confirmed a 46, XX karyotype, normal ovaries, and rudimentary uteri, with no renal or spinal anomalies.

In Case 1, epidural catheters were passed intraperitoneally and exteriorized through bilateral McBurney incisions. In Case 2, a retroperitoneal tunnelling approach was employed using the same incisions, avoiding additional skin punctures. Custom vaginal molds were prepared by drilling the apex to allow catheter passage, then covered with a condom and wrapped in paraffin-impregnated gauze containing 0.5% chlorhexidine acetate. Cystoscopy was routinely performed to exclude bladder injury.

The catheters were externally secured to coat buttons and adjusted daily to provide approximately 1 cm of upward traction per session. To minimize discomfort, a dose of epidural bupivacaine was administered 30 minutes before each adjustment. Traction continued until the desired vaginal length was achieved.

Results

Both procedures were completed in approximately 30 minutes without complications. By postoperative day 7, a neovaginal length of 9 cm was achieved. Catheters and molds were removed smoothly via the vaginal route. Both patients were discharged on postoperative day 8 with no signs of infection or trauma. At 6-month follow-up, vaginal length and patency were maintained, and both patients reported high satisfaction with functional and cosmetic outcomes.

Conclusions

These techniques offer safe, effective, and low-cost options for neovaginal creation in MRKH syndrome, enabling simultaneous traction and analgesia using a simple epidural catheter-based system.

<https://player.vimeo.com/video/1085267099?autoplay=1>

Feasibility of vaginal natural orifice transendoscopic surgery hysterectomy in obese patients

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Background

Obesity significantly influences the surgical landscape. Rising obesity rates are associated with various gynecological conditions, including menstrual irregularities, infertility, abnormal uterine bleeding, endometrial hyperplasia, and an increased risk of endometrial cancer due to enhanced estrogen conversion. Therefore, the rising obesity rates have led to a greater number of patients requiring hysterectomy. However, obesity is associated with increased perioperative risks, including higher rates of comorbidities, venous thromboembolism, and postoperative wound infections. Notably, minimally invasive surgical techniques significantly reduce these complications in obese patients. We assessed the feasibility and outcomes of vNOTES hysterectomy in obese patients.

Methods

We conducted a retrospective analysis of patients who underwent conventional laparoscopic surgery (CLS) or vNOTES hysterectomy at three multicenteric gynecology and obstetrics clinics between January 2020 and December 2024. Patients with a body mass index (BMI) ≥ 30 kg/m² were included.

Results

In total, 126 obese patients underwent CLS, and 42 underwent vNOTES hysterectomy. Estimated blood loss was calculated as 119 ± 81 and 146 ± 100 mL in the CLS and vNOTES groups, respectively. Operative time was significantly shorter in the vNOTES group (66.5 ± 14.9 min vs. 71.4 ± 12.8 min). The median hospital stay was comparable between the groups. Intraoperative complications occurred in one (0.8%) patient in the CLS group with a bladder injury. In the vNOTES group, two intraoperative complications were observed: one bladder injury (2.4%) and one rectal serosal injury (2.4%). Patients in the vNOTES group reported significantly lower visual analogue scale scores compared to the CLS group at 6, 12, and 24 h postoperatively. No significant differences were observed between the groups regarding additional analgesia requirements. Sexual function index and dyspareunia scores remained comparable between the groups at the 3-month postoperative follow-up.

Conclusions

Our findings suggest that vNOTES hysterectomy is a safe and feasible option for obese patients. In addition, the reduced postoperative pain associated with vNOTES may contribute to lower healthcare costs.

Laparoscopic revision of uterine isthmocoele with concomitant hysteroscopic guidance.
Demonstration of the surgical technique in simple reproducible steps.

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Background

Isthmoele or caesarean section niche, is a myometrial defect at a site of a previous lower segment caesarean section incision that results in the discontinuity or thinning of the uterine muscle layer over that area. Isthmoele has become an increasingly recognised condition associated with a global rise in caesarean section rates. Many women are asymptomatic and discovered incidentally during imaging or fertility evaluations. Symptomatic patients may present with abnormal uterine bleeding, pelvic pain, dysmenorrhea, or secondary infertility. The aetiology is multifactorial including inadequate surgical technique, impaired uterine wound healing, uterine retroflexion amongst others. Diagnosis is primarily made using transvaginal ultrasound scan or saline infusion sonohysterography. Management depends on the symptoms severity and fertility aspirations, ranging from conservative medical treatments to surgical intervention.

Methods

We are presenting a case of a 37-year-old female patient, Para 2 with two previous caesarean sections and intermittent intermenstrual spotting. Transvaginal ultrasound showed a uterine niche. Following counselling laparoscopic revision was offered and performed. The video offers a concise demonstration of the surgical technique in the following steps: 1) diagnostic laparoscopy and hysteroscopy, 2) deflection of the uterovesical fold and exposure of the uterine defect with Harmonic energy, 3) trans illumination of the defect hysteroscopically, 4) excision of defect with monopolar hook, and finally 5) two-layer uterine closure and haemostasis.

Results

The procedure was completed without perioperative complications. The postoperative course was uneventful, with patient experiencing resolution of symptoms.

Conclusions

Hysteroscopic resection may be the safest and most effective strategy in those patients with adequate residual myometrial thickness overlying the Isthmoele. Laparoscopic surgery may be the preferred option for patients with a thinner residual myometrium over the defect (<2,5 mm) and when hysteroscopic treatment is inconclusive. Awareness and early detection of Isthmoele are essential for preventing complications and optimizing patient outcomes, especially in women of reproductive age.

<https://player.vimeo.com/video/1090170379?autoplay=1>

Clinical characteristics of 30 patients with accessory cavitated uterine malformation: a nationwide multicenter study

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Background

Accessory cavitated uterine malformation (ACUM) is a rare female genital tract malformation that has been increasingly recognized over the last decade. However, its clinical characteristics remain underexplored due to the limited number of cases available for analysis. The primary objective of this study was to analyse the clinical features of patients diagnosed with ACUM. The secondary objective was to evaluate the therapeutic outcomes of surgical treatment in these patients.

Methods

A prospective study was conducted among 30 patients diagnosed with ACUM who were treated at five tertiary teaching hospitals in China between January 2022 and August 2024. Data were collected from medical histories, imaging studies (including pelvic ultrasonography and MRI), and surgical treatment. All information was recorded in the Chinese Female Reproductive Tract Malformation Registry Platform (<https://ecrf.linklab.com/>).

Results

The median age at diagnosis was 26 years, with a mean age at symptom onset of 19 years, resulting in a median diagnostic delay of 7 years. 18 patients have the lesions were located on the right side (60%), with 40% found on the left. Dysmenorrhea was present in all patients (100%), and pelvic endometriosis was comorbid in 28.57% of cases. Uterine malformations were present in 7% of patients, while urinary abnormalities and spinal deformities were found in 11.11% and 21.43% of patients, respectively. Surgical treatment resulted in complete relief of dysmenorrhea in 76.19% of patients and partial relief in 9.52%. All patients reported significant improvements in quality-of-life post-surgery, with no complications observed related to the surgical procedures.

Conclusions

ACUM is a rare congenital malformation frequently associated with delayed diagnosis due to low awareness. It can be comorbid with other uterine malformations, pelvic endometriosis, and urological or spinal abnormalities. Surgical resection of the lesions is an effective treatment, offering substantial improvements in both symptom relief and quality of life for the affected patients.

**Laparoscopic modified Davydov procedure in a patient with androgen insensitivity syndrome:
vaginal reconstruction using skin grafts**

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Background

Androgen insensitivity syndrome (AIS) is a rare X-linked disorder characterized by a 46, XY karyotype and resistance to androgen effects, resulting in a phenotypically female appearance with absent or hypoplastic vagina. In complete AIS, vaginal reconstruction is often necessary to achieve satisfactory anatomical and functional outcomes. The modified Davydov procedure, especially when performed laparoscopically, has emerged as a minimally invasive and effective technique.

Methods

We present a case of a 17-year-old patient with complete AIS who underwent laparoscopic modified Davydov vaginoplasty. A neovaginal canal was created between the bladder and rectum using laparoscopic dissection. Full-thickness skin grafts harvested from the pubic region were wrapped around a custom vaginal mould, which was inserted transperineally into the neovaginal cavity. Under laparoscopic visualization, the skin graft margins were sutured to the pelvic peritoneum to allow epithelialization over time.

Results

The procedure was completed without intraoperative complications, such as injury to the bladder, rectum, or pelvic vessels. The vaginal mould was maintained postoperatively for the required duration. Early follow-up demonstrated a well-epithelialized neovagina with satisfactory length and width. The patient experienced an uneventful recovery with good initial functional outcomes.

Conclusions

This case highlights the feasibility and effectiveness of laparoscopic modified Davydov vaginoplasty using autologous skin grafts in patients with AIS. The combination of peritoneal dissection and graft-supported epithelialization offers a reliable reconstructive approach. The laparoscopic method enhances surgical precision and reduces morbidity, making it a valuable option in the management of complex vaginal agenesis cases such as in AIS.

<https://player.vimeo.com/video/1090228789?autoplay=1>

Uterine AVM or Vascular Retention? Diagnostic Dilemma and Surgical Management in a Post-Abortion Patient

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Background

To report a case of acquired uterine arteriovenous malformation (AVM) following medical abortion, and to describe the diagnostic approach and alternative surgical management in the absence of embolization resources.

Methods

A 37-year-old woman, gravida 4 para 2 with two previous medical abortions, presented with persistent abnormal uterine bleeding (AUB) two months after her last pregnancy termination. Transvaginal ultrasound revealed a 20 × 24 mm heterogeneous intracavitary mass with marked hypervascularization on colour Doppler, intramyometrial vascularity, turbulent flow, and a peak systolic velocity (PSV) of 41 cm/sec. CT angiography identified a fundal vascular nidus measuring 24 × 16 mm, with intense arterial phase enhancement, suggestive of a uterine AVM. The findings were also compatible with a highly vascularized retained trophoblastic tissue (Akiba type 3 vascularization). Due to the unavailability of interventional radiology, the patient underwent bilateral laparoscopic hypogastric artery ligation followed by operative hysteroscopic resection.

Results

Surgical management was well tolerated without complications. Follow-up ultrasound at one month showed complete resolution of the intracavitary lesion and a thin, avascular endometrium.

Conclusions

In cases of persistent bleeding after abortion, the possibility of acquired uterine AVM or hypervascular retained products should be considered. When embolization is not feasible, a combined approach with vascular control and hysteroscopic resection may offer an effective and safe alternative treatment.

<https://player.vimeo.com/video/1089897856?autoplay=1>

Comparative Outcomes of Laparoscopic Vaginoplasty Techniques in MRKH Syndrome: A National Experience – Turkish Platform of Minimally Invasive Gynecologic Surgery (TR-MIGS)

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Background

Mayer-Rokitansky-Küster-Hauser (MRKH) syndrome is a rare congenital anomaly characterized by the absence of the uterus and upper two-thirds of the vagina. Creating a functional neovagina in these patients is essential for improving sexual quality of life and overall psychosocial well-being. Despite advances in surgical techniques, there is limited comparative data on the long-term sexual outcomes of different laparoscopic vaginoplasty methods. This study aims to evaluate and compare the long-term sexual function outcomes of various laparoscopic techniques used in the management of MRKH syndrome.

Methods

This multicenter retrospective study included patients with MRKH syndrome who underwent laparoscopic neovagina creation using one of three techniques: Uncu Modification, Davydov Method, or Vechietti Method. The study was conducted across three Turkish institutions: Bursa Uludağ University, Hacettepe University and Ankara University. Data collected included demographic characteristics, preoperative assessments, perioperative and postoperative complications, and long-term sexual function outcomes, evaluated using the Female Sexual Function Index (FSFI).

Results

A total of 103 patients underwent laparoscopic peritoneal vaginoplasty between 2008 and 2025 (75 at Uludağ University, 15 at Ankara University, 13 at Hacettepe University). The surgical techniques were distributed as follows: 73% (75/103) Uncu Modification, 12% (12/103) Davydov Method, and 15% (16/103) Vechietti Method.

Nine perioperative complications were recorded, including seven bladder injuries (7%) and two rectal serosal injuries (2%). Long-term complications included one vesicovaginal fistula (1%), two rectovaginal fistulas (2%), and three cases of vaginal stenosis (3%). There were no significant differences in complication rates among the surgical methods or centres.

All patients were examined at least one year postoperatively. The mean vaginal lengths were comparable among techniques: 8.4 ± 1.9 cm for Uncu Modification, 9.0 ± 1.5 cm for Davydov Method, and 8.1 cm for Vechietti Method. Mean FSFI scores also showed no statistically significant difference: 31.5 ± 3.9 (Uncu), 30.4 (Davydov), and 26.5 (Vechietti), with consistent results across all centres.

Conclusions

Laparoscopic vaginoplasty is a safe and effective option for MRKH patients who do not achieve sufficient vaginal length through self-dilation. The Uncu Modification, Davydov, and Vechietti methods demonstrate similar outcomes in terms of complication rates, neovaginal length, and long-term sexual function. The choice of technique may be guided by surgeon expertise and patient preference

A rare cause of chronic pelvic pain in childhood and its management; Noncommunicating Rudimentary Horn

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Background

Congenital uterine anomalies are observed in 0.15-0.5% of fertile women and 3.2% of infertile women. Unicornuate uterus with rudimentary horn is a rare Mullerian anomaly of the female genital system and constitutes 5-10% of uterine anomalies. In this anomaly, while the unilateral Mullerian duct develops normally, the other side shows abnormal maturation. In cases of partial or complete obstruction, clinical findings may occur from the first menstruation. To prevent possible complications in cavitated rudimentary horn, the horn should be excised when detected. Preferably, Laparoscopy (L/S) is a suitable option.

Methods

A thirteen-year-old patient who complained of chronic pelvic pain and previously complained of right groin pain applied to our clinic. In the patient's personal and family history, it was learned that she had her first menstrual period at the age of 12 and had dysmenorrhea since her first menstrual period. In the examination, the vulva vagina was observed as normal. In the pelvic USG, a tubular structure starting from the right ovary and evaluated as a 36 mm dense hematosalpinx at its widest point was observed. A rudimentary structure with a dense myometrium structure measuring 50 x 46 mm was observed on the right lateral side of this. In the pelvic MRI, a noncommunicating hemi uterus measuring 60x45 mm with haemorrhagic collection was observed on the right. Hematosalpinx was observed lateral to this. Bilateral ovaries were observed as normal. A left unicornuate uterus was observed.

Results

The patient underwent operative laparoscopy, right hemi uterus excision, right salpingectomy, vaginoscopy, and was discharged on the 3rd postoperative day.

Conclusions

The diagnosis of congenital anomalies of the mullerian system is difficult. Success in early diagnosis is possible with a good anamnesis and the appropriate use of imaging methods. Mullerian anomalies should be considered in the differential diagnosis of cases with a history of anomalies in the urinary system, chronic progressive pelvic pain, adnexal mass, and infertility, and the diagnosis should be confirmed with L/S.

<https://player.vimeo.com/video/1085806837?autoplay=1>

laparoscopic management of accessory cavitated uterine malformation (acum): a case report

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Background

To present the laparoscopic management of a rare congenital Müllerian anomaly—Accessory Cavitated Uterine Malformation (ACUM)—in a young woman with severe cyclic pelvic pain and to highlight the surgical steps and postoperative outcomes.

Methods

A 24-year-old nulliparous patient presented with chronic pelvic pain correlated with menstruation and irregular bleeding. Conservative management with hormonal therapy was unsuccessful. Transvaginal ultrasound revealed a well-circumscribed 3 cm cavitated lesion in the left anterior uterine wall. MRI confirmed a non-communicating accessory uterine cavity lined with functional endometrial tissue, suggestive of ACUM. After obtaining informed consent, laparoscopic excision was performed.

Results

During laparoscopy, a bulging mass was identified near the insertion of the left round ligament. Diluted vasopressin was injected to minimize bleeding. A precise incision was made, and the lesion was carefully dissected using cold scissors and bipolar coagulation. The cavity contained chocolate-like blood, consistent with functional endometrium. The accessory cavity was completely excised, and the myometrial defect was closed in multiple layers using absorbable sutures. The main uterine cavity remained intact. The patient had an uneventful recovery and was discharged on the second postoperative day. Histopathology confirmed the diagnosis of ACUM. At three-month follow-up, the patient reported complete resolution of pain and normalization of menstrual cycles.

Conclusions

ACUM is a rare but underrecognized cause of severe dysmenorrhea in young women. High-resolution imaging is essential for diagnosis, while laparoscopic excision is a safe and effective treatment, offering complete symptom relief and uterine preservation. A high index of suspicion is crucial for timely intervention and fertility preservation.

<https://player.vimeo.com/video/1085778465?autoplay=1>

long-term results of laparoscopically assisted Davydov (creation of a neo-vagina) technique

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Background

to examine the long-term effects of laparoscopically assisted Davydov technique to create a neovagina in patients with congenital vaginal agenesis due to Mayer-Rokitansky-Küster-Hauser (MRKH) Syndrome

Methods

retrospective cohort study enrolled a total of 25 women with MRKH syndrome. The patients underwent surgical creation of a neovagina by laparoscopic assisted Davydov technique from January 2009 to December 2023. Neovaginal length, sexual function, operative time, and complications were evaluated over a long-term follow-up (5 years).

Results

the mean operative time of the Davydov technique is 98 minutes (min 85-max 135). The mean neovaginal length at discharge is $8,3 \pm 0,5$ cm and 5 years after the Davydov technique is $9 \pm 0,4$ cm. The mean FSFI score at 5 years (Female Sexual Function Index) after the Davydov technique is $29,4 \pm 2,3$. Rectal injury occurred in one patient and the wounds were immediately detected and sutured (4%).

Conclusions

over a long-term follow-up (5 years), laparoscopic assisted Davydov technique successfully achieved optimal anatomic and functional outcomes in treatments of vaginal agenesis in MRKH syndrome.

Pregnancy After Hysteroscopy-Guided Laparoscopic Repair Of Caesarean Scar Defect: A Case Report

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Background

To report a successful pregnancy outcome after hysteroscopy-guided laparoscopic repair of a Caesarean Scar Defect (CSD) and to describe the 6-step surgical procedure.

Methods

case report

Results

Mrs. 28-year-old female, parity one, presented to Nunukan General Hospital with a chief complaint of postmenstrual spotting for the last two years. Her menstrual cycles had been regular during this period; however, she occasionally experienced spotting three days after the cessation of menstruation. Two years prior, the patient had consulted an obstetrician-gynaecologist, and an ultrasound examination revealed a defect in her caesarean scar. She was advised to be cautious regarding a subsequent pregnancy due to the thinness of the scar. Her obstetric history included a primary caesarean section for her first child due to active phase labour dystocia. Subsequently, she experienced one miscarriage, which was not managed by curettage. The patient expressed a desire for another pregnancy and had not used any form of contraception for two years. Pelvic examination revealed a uterus of normal size and shape. Cervical inspection showed a smooth cervix, with no abnormal discharge or active bleeding. Transvaginal ultrasound demonstrated a normal-sized uterus and adnexa, with a caesarean scar defect measuring 6.2 mm in width and a significantly thin residual myometrial thickness (RMT) of 1.2 mm.

Hysteroscopy-guided laparoscopic CSD repair was performed. The procedure involved the following 6 steps: Anatomical survey by inspection and palpation, mobilization of the bladder and development of the vesicovaginal space, hysteroscopic illumination to confirm the boundaries of the Isthmocele, haemostatic control, excision of the abnormal uterine scar tissue, re-approximation of the lower uterine segment.

The patient was discharged two days post-procedure. Eight months later, she presented at 6 weeks of gestation and was advised to attend regular antenatal check-ups. At 37 weeks of gestation, she delivered a healthy male infant weighing 2800 grams via caesarean section. During this subsequent caesarean section, the lower uterine segment was observed to be of adequate thickness, and the placenta was implanted in the fundus, not in the lower uterine segment.

Conclusions

Hysteroscopy-guided laparoscopic Caesarean Scar Defect (CSD) repair is a feasible and safe procedure. This case demonstrates that such surgical intervention can lead to the resolution of

symptoms like postmenstrual spotting and contribute to successful subsequent pregnancy outcomes, particularly in patients with a very thin residual myometrial thickness who desire future fertility.

<https://player.vimeo.com/video/1090776061?autoplay=1>

Outcomes of Hysteroscopic Isthmocele Repair

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Background

Isthmocele, a caesarean scar defect in the uterine isthmus, is increasingly recognized as a source of abnormal uterine bleeding, pelvic pain, and infertility. Hysteroscopic correction offers a minimally invasive approach for managing symptomatic Isthmocele. However, the extent of symptom resolution following this intervention remains an area of active investigation.

This study aims to evaluate the effectiveness of hysteroscopic resection in managing symptoms associated with Isthmocele.

Methods

This prospective case series included 54 symptomatic women diagnosed with Isthmocele via transvaginal ultrasound and hysteroscopy. Examinations were conducted in the early proliferative phase of the menstrual cycle. Isthmocele was defined as a myometrial indentation ≥ 2 mm. The niche's height and width were measured, and the area was calculated using the triangle area formula. Defects were classified according to Gubbini et al.:

- Grade I: $<15 \text{ mm}^2$
- Grade II: $16\text{--}25 \text{ mm}^2$
- Grade III: $>25 \text{ mm}^2$

Residual myometrium (RM) thickness was also measured. A cutoff of 2.5 mm RM was used; hysteroscopic correction was contraindicated in patients with $\text{RM} \leq 2.5 \text{ mm}$.

Hysteroscopic correction was performed in the operating room under spinal anaesthesia, using normal saline as the distending medium and a 9 mm bipolar loop resectoscope. Patients were followed up for symptom resolution and changes in uterine ultrasound findings.

Statistical significance was set as $p < 0.05$.

Results

Seventeen patients underwent hysteroscopic resection. All reported postmenstrual spotting lasting ≥ 5 days; six patients (35.3%) also experienced chronic pelvic pain. Nearly half (47%) had a history of two prior Caesarean sections, while only two patients (11.8%) had symptoms after a single Caesarean.

11 patients (64.7%) presented with grade II niche. Both grade I and grade III Isthmocele were identified in 3 patients respectively.

The hysteroscopic procedure was uneventful. Two patients reported transient urinary incontinence in the first postoperative week, which resolved spontaneously. No other complications were observed.

At two months post-procedure, 15 patients (88.2%) reported complete resolution of symptoms. At three months, this increased to 94.1%. Only one patient continued to experience postmenstrual spotting, though the duration had significantly decreased. This was significantly linked to having a bigger niche ($p < 0.01$).

Conclusions

Hysteroscopic correction of Isthmocele is a safe and effective treatment for symptom relief. The procedure is associated with high rates of symptom resolution and minimal complications.

Minimally Invasive Management of a Unicornuate Uterus with a Non-communicating Functional Rudimentary Horn

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Background

A unicornuate uterus with a non-communicating functional rudimentary horn is a rare congenital uterine anomaly, classified as U4aC0V0 according to the ESHRE/ESGE system. It results from incomplete fusion of the Müllerian ducts and often presents diagnostic challenges due to its low prevalence and nonspecific clinical symptoms.

Methods

This presentation involves human subjects and was approved by an institutional ethics committee. A 32-year-old woman presented with severe dysmenorrhea and primary infertility lasting seven years. Gynaecological examination revealed a single cervix and a normally structured vagina. Three-dimensional transvaginal ultrasound showed a unicornuate uterus with a left-sided, non-communicating rudimentary horn, a 6 cm haemorrhagic cyst in the left ovary, and a normal right ovary. Pelvic magnetic resonance imaging confirmed these findings and additionally revealed that the right fallopian tube was associated with the unicornuate uterus, while the left tube was connected to the rudimentary horn. A concomitant horseshoe kidney was also identified.

Diagnostic hysteroscopy demonstrated a single cervix and a small-volume uterine cavity, with visualization of only the right tubal ostium. No communication with the rudimentary horn was observed. Laparoscopy revealed a 4 cm rudimentary horn on the left uterine side. Complete resection of the horn with the left fallopian tube and excision of the haemorrhagic cyst was performed.

Results

The total operative time was approximately 60 minutes. Histopathological evaluation confirmed a functional rudimentary horn and a haemorrhagic cyst. The patient was discharged without complications on postoperative day one. At six-month follow-up, she remained asymptomatic with complete resolution of dysmenorrhea.

Conclusions

Unicornuate uterus with a non-communicating functional rudimentary horn should be considered in patients with dysmenorrhea and infertility. Minimally invasive surgery is essential for accurate diagnosis and effective treatment.

<https://player.vimeo.com/video/1085465403?autoplay=1>

Niche presence and changes of the uterine scar in the first year after caesarean section: A prospective longitudinal study

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Background

Currently, there is no consensus of the optimal timing for evaluating the uterine scar after a caesarean section. The aim of this study is to investigate the presence of uterine niches and changes in the uterine scar during the first year after a caesarean section and determine the optimal moment to evaluate the uterine scar post-caesarean section.

Methods

This prospective study included women who underwent their first caesarean section between May 2019 and November 2021. A transvaginal ultrasound was performed at four time points: six weeks, ten weeks, six months, and twelve months after the caesarean section. Data on niche presence and characteristics of the uterine scar were collected in a structured manner.

Results

The study included 94 women, with 79 (84.0%) women with repeated measurements. The number of women attending their ultrasound appointments decreased over time, n=73 at six weeks and n=53 at twelve months follow-up. At six weeks post- caesarean section, a niche was observed in 62/73 (84.9%) of the women, with 39/62 (62.9%) having a large niche, defined as a residual myometrial thickness/ adjacent myometrial thickness ratio of <50%. At twelve months post-caesarean section, the presence of a niche decreased to 41/52 (78.8%), with 22/41 (53.7%) having a large niche. The uterine scar characteristics changed over time. Mixed model analyses revealed a significant decrease in RMT between six weeks and six months (-1.1 mm, 95% CI: 2.0 - -0.2, p=0.02), followed by an increase between six and twelve months (+1.2 mm, 95% CI: 0.2 – 2.2, p=0.02). Furthermore, significant differences in scar characteristics over time were found; length, depth and width decreased up to six months.

Conclusions

Repeated evaluation of the uterine scar during the first year after a caesarean section, showed a decrease in residual myometrial thickness between six weeks and six months, followed by an increase up to twelve months. In line with a decrease in residual myometrial thickness during the first half year, niche prevalence also decreased. Other uterine scar measurements similarly changed up to six months after a caesarean section. Therefore, we consider six months to be the optimal time for uterine scar and niche evaluation. However, it is important to keep in mind that residual myometrial thickness may slightly increase between six and twelve months.

Laparoscopic Isthmocele repair guided by hysteroscopic transillumination in a patient with post-caesarean abnormal bleeding

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Background

Isthmocele, also known as caesarean scar defect, is a myometrial discontinuity at the site of a previous caesarean section. It may lead to postmenstrual spotting, pelvic pain, abnormal uterine bleeding, and secondary infertility. Laparoscopic repair is a minimally invasive and effective treatment option for symptomatic cases.

Methods

We present a 27-year-old female patient with a history of two caesarean deliveries. She reported heavy menstrual bleeding and foul-smelling discharge persisting for 1.5 years since her last delivery. Transvaginal ultrasonography revealed a 1.5 cm anechoic niche at the anterior uterine isthmus consistent with an Isthmocele. Laparoscopic repair was performed under general anaesthesia. Pneumoperitoneum was established using a Veress needle and four trocars were inserted. After lysis of mild adhesions, the vesicouterine peritoneal fold was dissected and the bladder was mobilized caudally to expose the defect. Hysteroscopic transillumination was used to precisely localize the Isthmocele. The fibrotic tissue was excised using laparoscopic scissors. The uterine defect was sutured in two layers with interrupted absorbable sutures (Vicryl® 2-0). The peritoneum over the bladder was closed continuously to minimize adhesion formation. Haemostasis was ensured through irrigation and electrocautery.

Results

The operation was completed without intraoperative or postoperative complications. Total operative time was 70 minutes. The patient was discharged on postoperative day one. During outpatient follow-up, menstrual regularity was restored and no further abnormal discharge was reported. Ultrasound confirmed satisfactory myometrial healing with no residual niche formation.

Conclusions

Laparoscopic repair of Isthmocele offers a definitive, fertility-preserving solution for symptomatic caesarean scar defects. This approach provides excellent visualization, enables complete excision and multilayer reconstruction of the uterine wall, and results in high patient satisfaction. It should be considered the standard of care in properly selected cases.

<https://player.vimeo.com/video/1085346223?autoplay=1>

An approach to complex Müllerian anomalies & resection of an isolated ureteric remnant

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Background

To illustrate a systematic diagnostic approach to complex Müllerian anomalies through an unusual case, and to present a stepwise surgical approach for the resection of an isolated ureteric remnant at a tertiary care centre in Toronto, Canada.

Methods

We present the case of a 36-year-old G0 female with multiple emergency department visits for copious purulent vaginal discharge that consistently improved with a combined oral contraceptive pill. Her medical history was notable for a solitary kidney and an unknown uterine reconstructive procedure. Pre-operative imaging revealed a dilated ectopic ureter, potentially explaining the discharge. Additionally, the radiographic findings suggested an OHVIRA syndrome, which contradicted the clinical examination. A decision was made to proceed with an examination under anaesthesia for definitive diagnosis and surgical resection of the ectopic ureter.

Results

We detail our multimodal diagnostic approach, which included vaginoscopy, hysteroscopy, and laparoscopy. This comprehensive evaluation revealed a previously resected uterine septum and an isolated ureteric remnant, effectively ruling out the initial diagnosis of OHVIRA syndrome. The remnant ureter was found to insert caudally into the vagina. A stepwise surgical resection technique was employed and is illustrated in this case. The patient was discharged home the same day, and the persistent purulent vaginal discharge resolved completely following the procedure.

Conclusions

In conclusion, Müllerian anomalies do not always follow textbook patterns. A stepwise, multimodal examination under anaesthesia, supported by a multidisciplinary approach, is essential for accurate diagnosis and management of such complex cases.

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Laparoscopic uterovaginal canalization and vaginoplasty for congenital cervical and vaginal atresia: long-term outcomes in 46 patients

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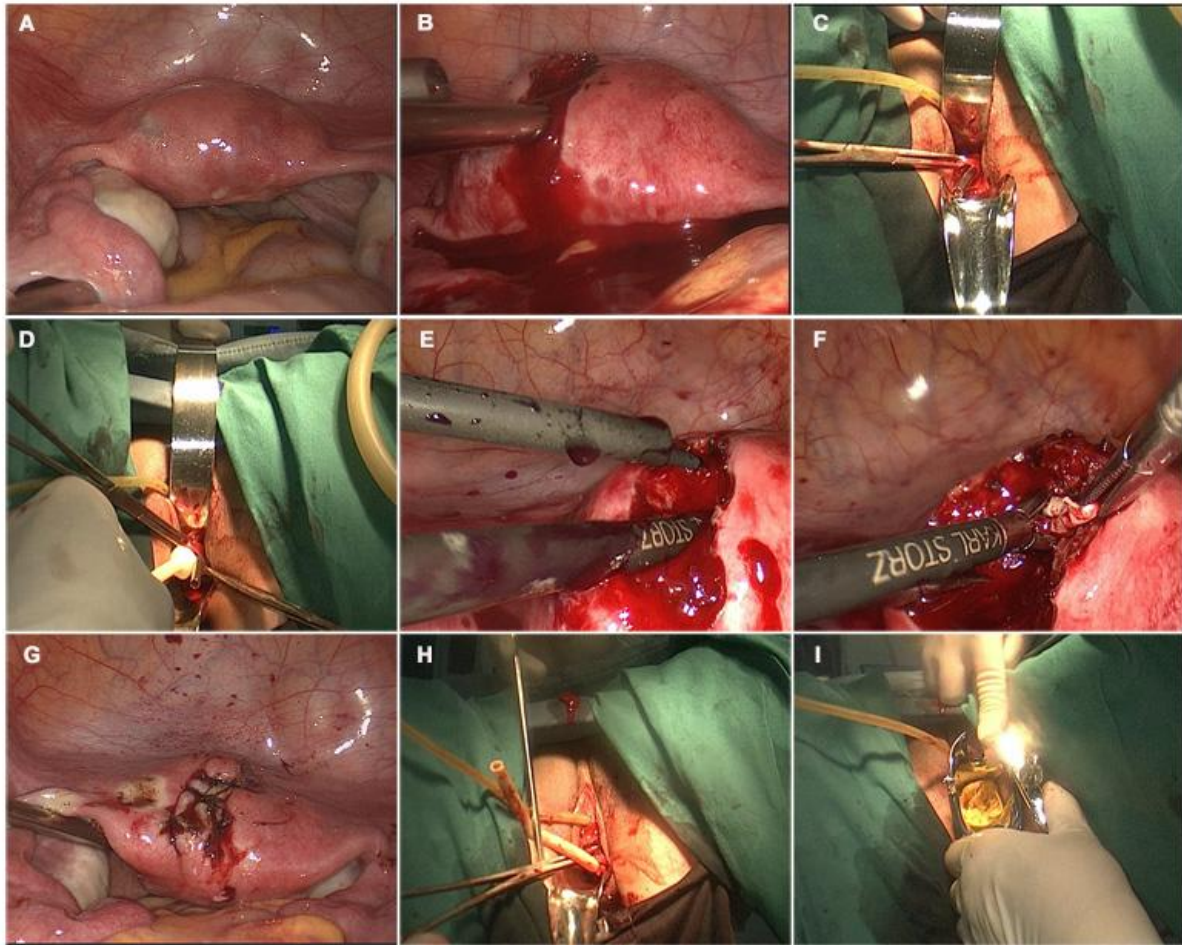
Background

Congenital cervical and vaginal atresia is a rare Müllerian anomaly that typically presents in adolescence with obstructed menstruation, severe cyclical pelvic pain, hematometra, and secondary endometriosis. Traditional management by hysterectomy eliminates reproductive potential and imposes a substantial psychosocial burden. Over the past few decades, a wealth of experience with conservative treatments has shown they can restore menstrual function and, in rare instances, even allow pregnancy. However, cervical recanalization is often complicated by restenosis, leading to repeat surgeries and carrying the risk of serious—and occasionally life-threatening—ascending infections. This study assesses the safety and efficacy of a standardized, laparoscopically assisted uterovaginal canalization and vaginoplasty technique in a larger patient cohort.

Methods

From January 2016 to January 2025, we prospectively enrolled 46 patients with congenital cervical and vaginal atresia at Peking Union Medical College Hospital. Each patient underwent a laparoscopic incision of the anterior uterine myometrium, after which a metal sound was used to canalize the tract into the newly created neovagina, which was then lined with a biological graft. A Pezzer catheter was positioned between the uterine cavity and neovagina to stent the neo-cervical canal, and long-term maintenance of both catheter and a vaginal mould—typically for 24 months—was used to preserve patency. Follow-up assessments occurred every three months during the first postoperative year and annually thereafter, evaluating menstrual function, neovaginal dimensions,

complications, sexual function, and pregnancy outcomes.



Results

After a median follow-up of 46.2 months (range, 9–108), all patients resumed menstruation; 89.1% (41/46) achieved regular cycles. Mild to moderate dysmenorrhea was reported by 37.0% (17/46). Anatomic success without restenosis was attained in 89.1% (41/46); complications included cervical restenosis in 4.3% (2/46) and vaginal adhesions in 6.5% (3/46). Mean postoperative vaginal length at final follow-up was 7.2 ± 1.5 cm. Reinterventions comprised cervical dilation in 8.7% (4/46) and stent replacement in 8.7% (4/46). One patient required hysterectomy for recurrent stenosis complicated by pelvic abscess. Preoperative pelvic endometriosis was noted in 41.3% (19/46), and four patients subsequently underwent ovarian cystectomy for endometriotic cysts. Of three sexually active patients, all reported satisfactory sexual function. No pregnancies occurred during the study period.

Conclusions

Laparoscopically assisted uterovaginal canalization and vaginoplasty is a safe, effective, fertility-preserving intervention for congenital cervical atresia, yielding favourable anatomic and functional outcomes. Prolonged stent placement and adherence to vaginal dilation protocols are essential to minimize restenosis. Further research is needed to evaluate long-term reproductive outcomes.

Efficacy of Hysteroscopic Isthmoplasty in Reducing Niche Dimensions and Postmenstrual Spotting: A Single-Center Prospective Study

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Background

Caesarean scar defects (Isthmocele) are increasingly recognized as a cause of abnormal uterine bleeding and secondary infertility. Hysteroscopic Isthmoplasty has emerged as a minimally invasive technique to address these symptoms, yet data regarding its standardized use and impact on reproductive outcomes remain limited. This study aimed to evaluate the clinical efficacy of hysteroscopic Isthmocele repair on niche dimensions, postmenstrual spotting, and fertility outcomes.

Methods

This was a prospective cohort study including 27 symptomatic women with a history of at least one caesarean section and a diagnosed uterine niche with a depth ≥ 2 mm and residual myometrium (RM) ≥ 2.5 mm on transvaginal ultrasound (TVU), as defined by the ISUOG guideline. Exclusion criteria included RM < 2.5 mm, uterine anomalies, irregular bleeding due to other causes, and noncompliance with follow-up. All procedures were performed by a single surgeon using a 7 mm bipolar resectoscope under general anaesthesia during the mid-proliferative phase. The standardized technique included four surgical steps: anatomical identification, resection of the cephalad and caudal fibrotic edges, and ablation of the base. Follow-up assessments were conducted at 3 months using 2D and 3D TVU.

Results

A total of 27 women were included, with a mean age of 33.4 years (± 3.69) and a mean body mass index (BMI) of 21.8 kg/m^2 (± 1.88). The median parity was 1 (range 1.0–2.0). The mean preoperative niche depth was 3.2 mm (range 2.0–7.0), and the mean residual myometrium was 2.9 mm (range 2.4–4.7). At baseline, 88.9% (24/27) of women reported postmenstrual spotting, 14.8% (4/27) had vaginal discharge, and 7.4% (2/27) reported pelvic pain. Secondary infertility was present in 22.2% (7/27) of the cohort. The mean operative time was 25.8 minutes (± 6.06), and one case (3.7%) had a minor complication.

Three months after the procedure, the mean niche depth significantly decreased to 0.9 ± 0.75 mm ($p < 0.001$). The proportion of women experiencing postmenstrual spotting dropped from 88.9% to 22.2% ($p < 0.001$), and the mean duration of spotting was reduced from 8.9 ± 5.4 days to 1.5 ± 2.3 days ($p < 0.001$). Among the seven women with secondary infertility, four (57.1%) conceived spontaneously within 12 months following surgery. No major complications occurred.

	Before surgery	3rd month after surgery	P value
Niche depth (mm)	3.2 (2.0–7.0)	0.9 (0.75)	<0.001

%Woman with spotting	24 (88.9%)	6 (22.2%)	-
Average days of spotting	8.90 ± 5.35	1.48 ± 2.34	<0.001
Spontaneous pregnancy in 12 months for woman desiring pregnancy (%)	NA	4/7 (57,1)	-

Conclusions

Hysteroscopic Isthmoplasty significantly reduced niche depth and improved postmenstrual spotting in symptomatic women. Additionally, favourable reproductive outcomes were observed in women with secondary infertility. These findings support hysteroscopic Isthmocele repair as an effective, minimally invasive treatment option, although further large-scale studies are warranted to confirm these results.

Molecular Subtype Differentiation in Endometrial Cancer Using Circulating Cell-Free DNA

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Background

Building on previous findings that serum cell-free DNA (cfDNA) can differentiate between long-term treatment outcomes and clinicopathological characteristics in uterine cancer, this study aims to assess the utility of cfDNA in predicting key molecular and clinical features of endometrial cancer (EC). With recent advances in molecular profiling, we sought to explore the potential of cfDNA as a predictive biomarker for EC characteristics.

Methods

This study prospectively recruited 115 women with endometrial cancer (EC) between January 2020 and April 2023. Blood serum samples were collected from patients prior to undergoing primary surgical treatment. Inclusion criteria required patients to have primary EC with no prior treatment for other cancers. Immediately after blood collection, serum was processed, and cfDNA was extracted from 1 mL of plasma using the ccfDNA/RNA Kit, followed by dilution in 20 µL of distilled water. cfDNA concentrations were measured using the High Sensitivity DNA Chip and 2100 Bioanalyzer (Agilent), with concentrations expressed as ng/mL of plasma. Associations between cfDNA concentration and both molecular subtypes—POLE-mutated (POLEmut), MMR-deficient (MMRd), no specific molecular profile (NSMP), and p53 abnormal (p53abn)—as well as traditional clinical characteristics, were analysed.

Results

The median age of participants was 67.5 years (range: 32–87 years), with a median BMI of 31 (range: 17–45). cfDNA was successfully extracted in 94% of cases (n=108), the median cfDNA levels were 5.9 ng/mL. cfDNA levels were significantly correlated with pre-operative CA125 levels ($r_s=-0.277$, $p=0.015$) and BMI ($r_s=-0.247$, $p=0.019$). No significant correlations were found between cfDNA concentration and traditional histopathological classifications, such as EC type or myometrial invasion ($p>0.210$ and $p>0.321$). However, cfDNA levels differed significantly across molecular subgroups ($p=0.007$). Women with POLEmut EC had the highest median cfDNA levels (23.1 ng/mL), while those with p53abn EC exhibited the lowest levels (4.5 ng/mL). MMRd EC was associated with higher cfDNA levels (7.8 ng/mL), whereas the NSMP group had lower levels (4.8 ng/mL).

Conclusions

This study demonstrates that cfDNA levels are significantly associated with molecular subtypes of endometrial cancer, particularly POLEmut and p53abn subgroups. While traditional clinical-pathologic features did not correlate strongly with cfDNA, these findings suggest cfDNA has the potential as a non-invasive biomarker for molecular profiling in EC, which could enhance personalised treatment strategies.

Preparation of paraaortic region before Laparoscopic paraaortic lymph node dissection: case compilation

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Background

Laparoscopic para-aortic lymph node dissection (LPLND) represents a cornerstone in the comprehensive management and staging of various oncological conditions, most notably in Gynecologic malignancies such as cervical, endometrial, and ovarian cancers. Its minimally invasive nature offers significant advantages over traditional open approaches, including reduced postoperative pain, shorter hospital stays, and faster recovery times. Preparatory phase, often underestimated, dictates the visibility of crucial anatomical landmarks, the ease of dissection, and ultimately, the minimization of iatrogenic injury to vital structures. This video presentation aims to elucidate the essential techniques and considerations for optimal para-aortic region preparation, laying the groundwork for a safe and effective laparoscopic lymphadenectomy.

Methods

The retroperitoneal para-aortic space is anatomically intricate, housing major vascular structures including the aorta, inferior vena cava (IVC), and their numerous tributaries (e.g., renal arteries and veins, gonadal vessels), along with the ureters and autonomic nerve plexuses. Lymphatic tissue is intimately associated with these vital structures.

Proper initial exposure and mobilization of surrounding tissues are paramount to overcoming these limitations. Without adequate preparation risk of complications such as major vessel injury, ureteral transection, or incomplete lymph node retrieval significantly increases. Therefore, optimizing the visualization and accessibility of the para-aortic region is a critical prerequisite for the successful execution of LPLND.

Results

This video presentation demonstrates the efficacy of a structured approach to para-aortic region preparation for LPLND. By systematically applying the techniques showcased, a consistently clear and optimized surgical field was achieved, significantly enhancing the safety and efficiency of subsequent lymph node dissection.

The video highlights how this meticulous preparation allows for:

- **Optimal Exposure:** Unimpeded access to the para-aortic and paracaval lymph node chains from the common iliac bifurcation up to the renal vessels.
-
- **Enhanced Safety:** Clear identification of the ureters and great vessels enabled precise dissection planes, demonstrably reducing the risk of iatrogenic injury.

-
- **Improved Efficiency:** The well-prepared field streamlined the lymph node dissection phase, potentially contributing to reduced operative times.

Conclusions

The preparation of the para-aortic retroperitoneal region is a fundamental and non-negotiable step for the successful and safe execution of laparoscopic para-aortic lymph node dissection. This video presentation underscores that optimal visualization, accurate anatomical identification, and meticulous development of surgical planes are critical determinants of surgical outcomes. By mastering these preparatory techniques, surgeons can significantly mitigate operative risks, enhance the efficiency of lymph node retrieval, and ultimately improve patient safety and long-term results in LPLND. As minimally invasive surgery continues to evolve, a thorough understanding and application of these foundational preparatory principles remain paramount for all practitioners undertaking complex retroperitoneal procedures.

Most important thing about this video is suspension of the colon by vascular sling or by passing a suture through the peritoneum is among the best methods that can be used.

<https://player.vimeo.com/video/1090284148?autoplay=1>

ESGE34-0847 -

Free Communication

Single-nucleus profiling of BRCA1/2-mutated high-grade serous ovarian cancer reveals immunotherapeutic implications

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Background

The intricacies of the tumor microenvironment (TME) in *BRCA*-mutant (*BRCA*-mut) high-grade serous ovarian cancer (HGSOC) remain underexplored, significantly impeding the clinical management of this subset. Characterizing the unique TME features of *BRCA*-mut HGSOC is imperative for tailored therapeutic interventions.

Methods

We analysed tumor samples from nine HGSOC patients, comprising six with *BRCA*-mut and three with *BRCA* wild-type (*BRCA*-WT), using advanced single-nucleus RNA sequencing (snRNA-seq).

Results

Through snRNA-seq, we profiled 130,110 single nuclei from both *BRCA*-mut and *BRCA*-WT HGSOC tumours. The *BRCA*-mut tumours exhibited a higher abundance of TCF7⁺ CD8⁺ T cells and a reduced presence of PDCD1⁺ CD8⁺ T cells and CD274⁺ macrophages compared to their *BRCA*-WT counterparts. Significantly, TCF7⁺ CD8⁺ T cells in *BRCA*-mut tumours displayed a stem-like memory phenotype, whereas PDCD1⁺ CD8⁺ T cells in *BRCA*-WT HGSOC were terminally exhausted. A higher proportion of TCF7⁺ CD8⁺ T cells correlated with favourable prognoses and enhanced responses to

immunotherapies. Conversely, increased levels of PDCD1⁺ CD8⁺ T cells and CD274⁺ macrophages were associated with poorer outcomes. Differential gene expression and interaction analysis revealed that CD274⁺ macrophages in *BRCA*-WT tumours potentially drive the differentiation of TCF7⁺ CD8⁺ T cells into terminally exhausted PDCD1⁺ CD8⁺ T cells via the CD274/PDCD1 pathway.

Conclusions

This detailed analysis of the *BRCA*-mut HGSOC immune landscape offers crucial insights into immune evasion strategies, thereby facilitating the development of more effective immunotherapeutic approaches and enhancing patient stratification.

Long-Term Outcomes of Laparoscopic-Assisted Vaginal Radical Trachelectomy: Case Series from a Tertiary Hospital

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Background

Laparoscopic-assisted vaginal radical trachelectomy (LAVRT) is a fertility-preserving surgical option for nulliparous patients diagnosed with early-stage cervical cancer. For tumours smaller than 2 cm, oncological outcomes of radical trachelectomy are comparable to those of radical hysterectomy. Moreover, among the various surgical approaches, LAVRT is associated with superior obstetric outcomes compared to the abdominal route.

Methods

We retrospectively reviewed cases of trachelectomy performed in our department over an eight-year period.

Results

Between January 2017 and December 2023, seven patients underwent LAVRT at our institution.

- **Case 1:** A 35-year-old woman with a history of two LEEP procedures and a final diagnosis of adenocarcinoma with a 7 mm depth of invasion underwent surgery in May 2019.
- **Case 2:** A 31 years old patient with a 2 cm tumor detected on a prior LEEP with no residual tumor underwent LAVRT in June 2019.
- **Case 3:** A 29-year-old kidney transplant recipient with three prior LEEP procedures and residual CIN III in the endocervical canal underwent a simple trachelectomy in October 2020.
- **Case 4:** A patient (28 years old) with a 1 cm squamous cell carcinoma underwent LAVRT in December 2019.
- **Case 5:** A 35-year-old woman with a 2 cm tumor was planned for LAVRT. However, intraoperative frozen section analysis revealed a metastatic pelvic lymph node. The procedure was converted to laparoscopic pelvic and paraaortic lymphadenectomy with ovarian transposition. She was referred for concurrent chemoradiotherapy. At 12-month follow-up, she developed supraclavicular nodal and pulmonary metastases. She had a positive PD-L1 score and was subsequently treated with chemotherapy and pembrolizumab.
- **Case 6:** A 39-year-old woman with a 15 mm tumor underwent LAVRT in October 2022. She later reported menstrual irregularities resistant to hormonal therapy.
- **Case 7:** A 39-year-old nulliparous woman with two prior LEEP procedures and residual CIN III at the endocervical margin underwent simple trachelectomy in May 2023.

The mean operative time was 290 minutes. One complication—bladder perforation during the vaginal phase—was repaired intraoperatively without sequelae. No blood transfusions were required.

Two term pregnancies were achieved by the same patient, both resulting in live births at 37 weeks. This patient required laparoscopic abdominal cerclage replacement due to cerclage exposure and suture loosening.

Cytologic follow-up in one patient revealed HSIL, managed with a shallow LEEP; LSIL persisted on subsequent cervical biopsy.

With a median follow-up of 60 months (range: 15–63 months), no local recurrences were observed.

Conclusions

LAVRT is a feasible fertility-sparing surgical technique with acceptable oncologic safety in well-selected early-stage cervical cancer patients. However, despite its fertility-preserving intent, the actual pregnancy rate remains low, with only two live births among seven patients.

ESGE34-0674 -

Free Communication

Reno-vascular variations encountered in Gynecologic oncology surgeries: a tertiary centre single surgeon experience

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Background

to identify common reno-vascular anatomical variations during retroperitoneal space surgery to avoid possible major vessel injury in the para-aortic region and complications that may lead to kidney loss.

Methods

patients who underwent paraaortic lymph node dissection and were operated on by a single surgeon at the Gynaecological Oncology Surgery Clinic of Etlik City Hospital between March 2024 and February 2025 were evaluated in this study.

Results

para-aortic lymph node dissection was performed by laparoscopy/laparotomy in 42 patients by a single surgeon in 12 months. Retro aortic left renal vein was detected in 4 (9.5%) of these patients, while accessory polar renal artery was detected in 5 (11.9%). The location of the polar arteries was bilateral inferior in 2 patients, right inferior in 2 patients, and right superior in 1 patient. Intraoperative vascular damage did not occur in any patient with a variation. While the incidences of

surgeon-based variations were consistent with the literature for the polar renal artery, our incidence of retro aortic left renal vein was higher.

Conclusions

The renal vascular system is large and has significant variation, so detailed anatomical knowledge of renal vascular variation is important for clinical and surgical procedures. Because the accessory polar renal artery is functional, it is very important to avoid injury to this vessel, especially during para-aortic lymph node dissection. Similarly, retro aortic left renal vein injury may lead to kidney loss. Therefore, before starting para-aortic lymph node dissection, the left renal vein must be visualized and the dissection borders must be determined safely. Before surgery, if possible, a contrast-enhanced abdominal tomography of each patient should be evaluated by the senior surgeon, and any possible vascular variation should be determined in advance and surgical planning should be made accordingly. Gynecologic oncologist experience and mastery of retroperitoneal vascular anatomy are important to prevent unintentional vascular damage.

Artificial Intelligence-Enhanced Smartphone Imaging Versus Conventional Colposcopy for Detecting Cervical Premalignant Lesions: A Prospective Diagnostic Accuracy Study

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Background

Cervical cancer is a leading gynaecological malignancy globally, especially in low-resource settings. Early detection, primarily via Pap smear and HPV testing, is critical. Colposcopy remains the gold standard for evaluating suspicious lesions but requires equipment and trained personnel, limiting its accessibility and reliability in underserved regions. Recent advances suggest that artificial intelligence (AI) integrated with smartphone-based imaging may offer an accessible, objective alternative. This study aimed to evaluate the diagnostic performance of a smartphone-based AI model against conventional colposcopy-guided biopsy in detecting cervical premalignant lesions.

Methods

In this prospective cohort study, 267 women aged 30–60 years underwent colposcopy for abnormal Pap smear, HPV positivity, postcoital bleeding, or suspicious cervical lesions. Exclusion criteria included age outside the range, pregnancy, prior cervical procedures, malignancy or inability to visualize the transformation zone. Following standard colposcopy, high-risk lesions were biopsied. Prior to biopsy, 4–5 high-resolution cervical images were captured per patient using a smartphone post-acetic acid application and archived for AI analysis. Clinical, colposcopic, and histopathological data were recorded.

The AI system was initially trained on a dataset of 100 images classified as normal, low-grade (CIN1), or high-grade lesions (CIN2, CIN3). It employed a deep learning convolutional neural network model using TensorFlow and Keras frameworks. Input images underwent preprocessing, including normalization and augmentation, to improve performance. The model was optimized with the Adam algorithm and ReLU activation functions, trained over 20 epochs with a batch size of 64. After training, the AI algorithm classified study images into normal, low-grade, or high-grade lesion categories. Diagnostic performance was evaluated by comparing AI classifications with histopathological gold standards, calculating sensitivity, specificity, and accuracy.

Results

The mean age of the participants was 45.03 ± 8.48 years, 72.6% were premenopausal. Colposcopy indications included HPV positivity in 136 patients (51.1%), abnormal smear in 82 (30.8%), and visible cervical lesions in 48 (18.0%). Histopathology revealed benign findings in 161 patients (60.5%), CIN1 in 74 (27.8%), CIN2 in 13 (4.8%), and CIN3 in 18 patients (6.7%).

Of the 266 valid image sets, the AI system correctly classified 183. Class-specific accuracies were: normal (70.2%), CIN1 (67.5%), CIN2 (61.5%), CIN3 (66.6%). When stratified into benign lesions (normal and CIN1, n=235) and preinvasive lesions (CIN2 and CIN3, n=31), the AI system identified 175

benign and 28 preinvasive lesions correctly, yielding detection rates of 74.4% and 90.4%, respectively.

Conclusions

The AI model showed strong concordance with histopathological results, particularly in identifying preinvasive lesions. These findings support the potential of smartphone-based AI as a practical screening tool in settings lacking access to expert colposcopy. It may assist clinicians in triage decisions and expand screening capabilities. Nevertheless, larger-scale validation is necessary before clinical integration.

Risk of Unexpected Gynecologic Malignancies in Women Undergoing Sacrocolpopexy with Subtotal Hysterectomy and Salpingo-Oophorectomy for Prolapse

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Background

Pelvic Organ Prolapse (POP) is a frequent issue among elderly women, with a prevalence ranging from 15% to 50%. Sacrocolpopexy is considered the gold standard for POP surgery and is often performed alongside subtotal hysterectomy (SH) and bilateral salpingo-oophorectomy (BSO). Although unanticipated premalignant or malignant findings following POP surgery are rare (average reported prevalence of 0.2% to 3%), thorough preoperative assessment is recommended, including accurate medical history, physical examination, cervical cancer screening, pelvic ultrasonography, and endometrial sampling in case of abnormal findings.

Methods

This retrospective cohort study evaluates the prevalence of unexpected pathology among patients with normal preoperative assessments. Electronic medical records of 421 patients who underwent sacrocolpopexy, SH and BSO between January 2022 and December 2023 were reviewed for demographics, medical history, preoperative workup, and final pathology. Frequencies of abnormal pathologies were calculated, and demographic and screening factors were analysed using the Fisher exact test or Mann-Whitney *U*-test.

Results

Demographics and pathology details are reported in Table 1. No significant differences were noted in premalignant/malignant pathology based on age, BMI, and POP-Q stage. Out of 421 patients, 18 (4.3%) had premalignant or malignant findings, including 13 (3.1%) patients with atypical endometrial hyperplasia, one case (0.2%) of serous tubal intraepithelial carcinoma (STIC), one (0.2%) smooth uterine muscle of uncertain malignant potential (STUMP). Three (0.7%) occult malignancies were identified including 2 (0.5%) low-grade endometrioid endometrial carcinoma (FIGO stage IA2) and one (0.2%) clear cell ovarian carcinoma (FIGO stage IA). Four (0.8%) patients subsequently underwent appropriate surgical restaging according to guidelines, which included trachelectomy and mesh removal in endometrial cancer cases.

Table 1: Demographics and pathology details.

Demographics	Benign Pathology (n=403)	Premalignant/Malignant Pathology (n=18)	P-value
Age (years), median (range)	67 (42–81)	70 (48–81)	0.41
BMI (kg/m ²), median (range)	25 (19–33)	26 (21–32)	0.31
Parity, median (range)	3 (1–5)	2 (1–4)	0.75
Menopause, N (%)	390 (97%)	17 (94%)	0.13
Preoperative POP-Q stage (range)	3 (2–4)	3 (2–4)	0.45

Pathology Report – Site and MDT Decision

Pathology Type	N (%)	MDT Decision
Benign Pathology	403 (95.7%)	n/a
Premalignancy and Gynaecological tumours of uncertain malignant potential	15 (3.6%)	
— Endometrial Atypical Hyperplasia (Uterus)	13 (3.1%)	Follow up
— STIC (Ovary/Fallopian Tubes)	1 (0.2%)	Restaging surgery: peritoneal biopsies, omentectomy
— STUMP (Uterus, uncertain malignant potential)	1 (0.2%)	Follow up
Malignancy	3 (0.7%)	
— Low-grade Endometrioid Endometrial Carcinoma (Uterus)	2 (0.5%)	Restaging surgery: laparoscopic trachelectomy, complete mesh removal, sentinel lymph-node biopsy
— Clear Cell Ovarian Carcinoma (Ovary/Fallopian Tubes)	1 (0.2%)	Restaging surgery: laparoscopic peritoneal biopsies, omentectomy, pelvic and para-aortic lymphadenectomy

Conclusions

POP patients have a minimal but not negligible risk of abnormal pathology, despite normal preoperative workup. Our study potentially contributes to enhance preoperative assessment and counselling process for identifying premalignant and malignant gynaecological lesions in seemingly low risk patients.

A Less Common Location of Sentinel Lymph Node: Presacral Region

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Background

Sentinel lymph node (SLN) mapping using indocyanine green (ICG) and near-infrared fluorescence has become standard in the surgical staging of endometrial carcinoma. While SLNs are typically located in the external iliac and obturator regions, they may also appear in uncommon locations, such as the presacral space. These atypical sites may be missed if not systematically explored. This video aims to highlight the importance of thoroughly inspecting the presacral area during SLN mapping.

Methods

A 62-year-old postmenopausal woman was diagnosed with grade 1 endometrioid adenocarcinoma after presenting with abnormal uterine bleeding. PET imaging revealed a 2×2 cm hypermetabolic lesion in the posterior uterine corpus. The patient underwent total laparoscopic hysterectomy, bilateral salpingo-oophorectomy, and SLN mapping using cervical injection of ICG. One millilitre of ICG was injected superficially and deep at both the 3 and 9 o'clock positions of the cervix. Fluorescence-guided laparoscopy was used to visualize lymphatic drainage pathways.

Results

SLNs are usually identified bilaterally in the external iliac and obturator regions, and notably, in this case, in the presacral region. The video demonstrates the left-sided SLN in the presacral region. Demonstrating dissection technique, with anatomical orientation and safe handling of adjacent structures. Final pathology revealed FIGO grade 3 endometrioid adenocarcinoma, <50% myometrial invasion, p53 mutation positivity, no lymph vascular invasion, negative POLE mutation, and no mismatch repair deficiency. Ultra staging revealed that SLNs were negative for metastasis. According to the FIGO 2023 Classification, it is classified as IICm p53 abn. The patient was referred for adjuvant chemotherapy.

Conclusions

This video underlines the importance of including the presacral area in the SLN mapping protocol. Awareness of atypical drainage patterns and thorough exploration can enhance surgical staging accuracy and influence adjuvant treatment decisions.

<https://player.vimeo.com/video/1085625343?autoplay=1>

Laparoscopic radical hysterectomy after the LACC trial, avoiding uterine manipulator, pre-colpotomy vaginal washing and clamping, and uterine removal using a retrieval bag: a retrospective study

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Background

In Japan, laparoscopic radical hysterectomy (LRH) has been covered by national health insurance since April 2018, and its implementation is permitted in facilities registered with the Japan Society of Obstetrics and Gynecology. Many of these facilities take precautions such as preventing cancer cell spillage during vaginal cuff incisions and avoiding the use of a uterine manipulator. However, reports on long-term outcomes remain limited. At our institution, LRH was introduced in October 2019 following sufficient patient counselling after the publication of the LACC trial.

We aimed to retrospectively evaluate and compare the relapse-free survival (RFS) between abdominal radical hysterectomy (ARH) and LRH while avoiding uterine manipulator, vaginal washing and clamping before colpotomy, as well as uterus removal with retrieval bag.

Methods

This study included patients with cervical cancer, classified by the International Federation of Obstetrics and Gynaecologists (FIGO 2018) as stage IB1–IIB, who underwent radical hysterectomy at our institution between October 2019 and April 2025. This research was conducted in accordance with the ethical standards set forth in the Declaration of Helsinki and received approval from the institutional review board (IRB approval number: S24-110).

Results

Overall, 111 patients with cervical cancer who underwent radical hysterectomy were included in this study. ARH was performed in 78 patients and LRH in 33. The median follow-up periods were 60 and 45 months for patients who underwent ARH and LRH, respectively. Five-year RFS was 86.9% in the ARH and 96.7% in LRH group, no significant difference was observed in the RFS between the ARH and LRH groups. After adjusting for inverse probability weighting, there was no significant difference in the RFS between the ARH and LRH groups. Similarly, no significant difference in overall survival was observed between the two groups.

The only recurrence site in the LRH group was the vaginal stump, and we did not observe any pattern of recurrence involving multiple intraperitoneal disseminations as reported in the LACC trial.

Conclusions

The RFS after LRH in patients with early-stage cervical cancer was not significantly different from that in patients who underwent ARH when avoiding uterine manipulator and tumor isolation method.

Because this study was conducted at a single institution with a limited number of cases. As a prospective multicenter trial, enrolment in the non-randomized confirmatory trial of minimum invasive LRH in patients with early-stage cervical cancer) trial is ongoing, and the results are anticipated to determine whether oncologic outcomes can be ensured in a prospective setting.

Minimally Invasive Surgery for Unusual Cervical Cancer Recurrences: A Tailored, Multidisciplinary Approach

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Background

Managing recurrent cervical cancer remains a significant clinical challenge, especially in advanced stages where therapeutic decisions depend largely on previous treatments and the anatomical site of recurrence. Involvement of the gastrointestinal tract, particularly the small and large intestines, is infrequent. Although some evidence points to improved survival following radical secondary surgery in select cases, this strategy remains insufficiently studied, with most reports centring on recurrences in abdominal lymph nodes, visceral metastases (e.g. lung), or pelvic exenteration.

Methods

We present the case of a 45-year-old woman with FIGO stage IIIC1 cervical cancer who developed an isolated recurrence in the sigmoid colon. Her initial treatment included concurrent chemoradiotherapy followed by brachytherapy. At a 15-month follow-up, CT and PET scans identified a hypermetabolic 40-mm lesion in the sigmoid colon, with possible encasement of the inferior mesenteric artery. After evaluation by a multidisciplinary tumor board, the patient underwent a laparoscopic rectosigmoid resection with a primary end-to-end anastomosis. The surgical specimen was retrieved through a mini Pfannenstiel incision. No additional lesions were found intraoperatively, and the vaginal cuff showed no signs of disease. The procedure was recorded step-by-step to detail the surgical approach.

Results

A complete (R0) resection was successfully performed. The patient had no intraoperative or postoperative complications and recovered smoothly. Histology confirmed a 4.5 cm metastatic squamous cell carcinoma infiltrating the entire bowel wall, with clear resection margins. Given the tumor's PD-L1 positivity, adjuvant platinum-based chemotherapy combined with immunotherapy was proposed by the multidisciplinary team.

Conclusions

Minimally invasive surgery for isolated recurrence of cervical cancer is a viable and effective option, offering the benefits of lower morbidity and faster postoperative recovery. High-resolution preoperative imaging, including 3D reconstruction, can significantly aid in surgical planning and ensure complete tumor removal and subsequent molecular analysis. This case highlights the value of an individualized, multidisciplinary approach to both surgical and adjuvant treatment. As molecular profiling, targeted therapies, and immunotherapy continue to advance, individualized treatment

strategies may further improve oncological outcomes, reduce recurrence rates, and expand therapeutic options for complex cervical cancer recurrences.

<https://player.vimeo.com/video/1085446403?autoplay=1>

Management of Endometrial Serous Carcinoma Via vNOTES in an Elderly Patient: A Feasible Approach in Geriatric Gynecologic Oncology

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Background

Endometrial serous carcinoma (ESC) is a high-grade, non-endometrioid subtype of endometrial cancer with a typically aggressive course. Comprehensive surgical staging is essential. While minimally invasive approaches are preferred, their application in elderly patients with multiple comorbidities is limited. This case highlights the feasibility of vNOTES in such a setting.

Methods

An 81-year-old woman (G6P3A3), with known diabetes, hypertension, chronic obstructive pulmonary disease, and a history of 60 pack-years of smoking, presented with postmenopausal bleeding. Endometrial sampling revealed serous carcinoma. Transvaginal ultrasound showed atrophic ovaries and an irregular, thickened endometrium measuring 9 mm. MRI revealed a 15×22 mm lesion extending into the myometrium, with possible superficial extrauterine extension. No suspicious lymphadenopathy was detected. PET-CT demonstrated minimal heterogeneous FDG uptake in the uterine fundus without evidence of nodal or distant metastasis.

A total hysterectomy with bilateral salpingo-oophorectomy was performed via the V-NOTES approach. Sentinel lymph node mapping was attempted but failed; thus, total pelvic lymphadenectomy and infracolic omentectomy were performed. No intraoperative or postoperative complications occurred. The patient was discharged on postoperative day 2 without ICU requirement.

Results

Pathology confirmed high-grade endometrial serous carcinoma measuring 2×1.5 cm with 94% myometrial invasion (16/17 mm), lower uterine segment, and cervical stromal involvement, but no lymph vascular invasion. All resected lymph nodes (0/8) and omentum were tumor-free. Surgical margins were negative.

Conclusions

This case illustrates the potential for V-NOTES to be used effectively in elderly patients with high-risk endometrial cancer. Despite advanced age and comorbidities, the patient underwent complete staging surgery with rapid recovery and no complications. V-NOTES can offer a less invasive yet oncological sound option in carefully selected geriatric oncology cases.

<https://player.vimeo.com/video/1085087702?autoplay=1>

Treatment Strategy for Advanced Ovarian Cancer Difficult to Resect Completely: Indications and Techniques of Diagnostic Laparoscopy

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Background

In patients with advanced ovarian cancer where complete cytoreduction is not feasible at initial presentation, neoadjuvant chemotherapy (NACT) followed by interval debulking surgery (IDS) has become the standard approach. Histological confirmation prior to chemotherapy is essential, particularly for homologous recombination deficiency (HRD) testing, which plays a key role in determining eligibility for targeted maintenance therapy. Diagnostic laparoscopy offers a minimally invasive means for obtaining tissue samples, allowing early initiation of systemic treatment. However, challenges such as tissue fragmentation, insufficient sample volume, and port-site metastasis must be addressed through careful procedural planning.

Methods

At our institution, we generally employ diagnostic laparoscopy for tissue sampling in patients with unresectable advanced ovarian cancer, except in cases with extremely bulky tumours where exploratory laparotomy may be considered. For the laparoscopic procedure, a 2–4 cm umbilical incision is made, through which a Lap Protector and E · Z Access device are inserted. This system provides access for both visualization and biopsy, while preventing direct contact between the tumor and the wound. Two trocars are placed through the same umbilical site to reduce the total number of ports, thereby minimizing the risk of port-site metastasis. Postoperatively, patients remain hospitalized and chemotherapy is initiated without delay. HRD testing is performed during NACT, and results are used to guide maintenance therapy following IDS.

Results

Diagnostic laparoscopy was successfully performed in all indicated cases without major complications. Adequate tumor tissue was obtained for both histopathological diagnosis and HRD testing. The use of wound protection and single-site port placement helped to prevent tissue fragmentation and eliminate tumor contact with the incision. There were no cases of port-site recurrence observed during follow-up. Early initiation of chemotherapy during hospitalization was consistently achieved. HRD test results were available in time to guide decisions regarding the use of PARP inhibitors or other maintenance therapies following IDS.

Conclusions

Our diagnostic laparoscopic strategy provides a safe and efficient method for tissue acquisition in advanced ovarian cancer unsuitable for primary debulking surgery. By using wound protection devices and minimizing port numbers, we reduce the risks of procedural complications while maintaining diagnostic accuracy. This approach facilitates prompt initiation of chemotherapy and integration of HRD testing into clinical decision-making. Diagnostic laparoscopy, when carefully

executed, is a valuable component in the personalized treatment pathway for patients with advanced ovarian cancer.

Laparoscopic staging of endometrial cancer: combined technique

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Background

Clinical case

Chief complaint

Postmenopausal bleeding

5 month long postmenopausal bleeding associated to moderated pelvic pain

Past medical history

Negative for chronic illness or medication

Menarche: 13 yo - Menopause: 52 yo - G9P8A1V8

Physical examination

Weight: 85cm - Height: 1.6m - BMI: 33.2

Vaginal examination: atrophic vagina and cervix, no lesions, 8cm uterus, elastic parametria

Methods

Endometrial adenocarcinoma FIGO 2 - MMRD

TV scan: endometrial thickness 28mm

Endometroid endometrial carcinoma FIGO 2

Endometrial biopsy

IMHQ: MMRD

Diagnosis

Plan

Laparoscopic stratification of endometrial cancer: combined technique

Results

Later, Vasilev and McGonigle⁶ started an entirely extraperitoneal laparoscopic technique for para-aortic lymphadenectomy in a pig model, followed by application to humans in 1996, and Dargent et al⁷ developed this procedure systematically.

Abdominal lymphadenectomy with a large incision may lead to some complications, such as abdominal incisional pain, bleeding, infection, or intestinal obstruction, not to mention the delay it will cause to postoperative adjuvant therapy, if indicated, waiting for the large wound to heal. Compared with laparotomy, laparoscopic lymphadenectomy can decrease these complications.

There are many literatures about the safety and feasibility of laparoscopic staging surgery in Gynecologic malignancies.⁸

Conclusions

Extraperitoneal lymphadenectomy is started by separating the anterior abdominal wall peritoneum to the preperitoneal fat and muscles at the upper quadrant trocars until enough working space is created and until the mentioned landmarks are seen. Dissection of the para-aortic and paracaval nodes and the surrounding tissues is performed cranially from the common iliac to renal vein.

<https://player.vimeo.com/video/1085859456?autoplay=1>

Predictive Value of Diagnostic Criteria for Septate Uterus on Postoperative Reproductive Outcomes: A Comparative Study.

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Background

The aim of the study is to investigate the predictive value of ESHRE/ESGE 2013 diagnostic criteria for septate uterus compared to CUME 2018 and ASRM 2021 criteria —in relation to postoperative reproductive outcomes.

Methods

This is a retrospective study conducted at the University of Naples "Federico II" from January 2022 to January 2025. Patients referring primary or secondary infertility or recurrent pregnancy loss who underwent hysteroscopic metroplasty with a diagnosis of septate uterus were included. Diagnosis of uterine septa was done both with diagnostic hysteroscopy and 3D ultrasound with coronal reconstruction. Each patient was retrospectively categorized according to one of the following diagnostic ultrasonographic criteria: ESHRE/ESGE (internal indentation length $\geq 50\%$ of the uterine wall thickness), CUME (indentation depth $\geq 1\text{cm}$), or ASRM (indentation depth $>1\text{ cm}$ and the angle of septa $<90^\circ$). Patients underwent surgery in operating room or outpatient clinic setting, with 26, 27 and 15 fr resectoscope or 5 fr miniaturized instruments. Postoperative reproductive outcomes including clinical pregnancy rate (CPR), live birth rate (LBR), and miscarriage rate (MR) were evaluated after 6 months from surgery, every 6 months.

Results

95 patients were recruited, subdivided according to diagnostic criteria as follows: ESHRE/ESGE (n=44), CUME (n=32), or ASRM (n=19). After surgery, the CPR was 75 % for ESHRE/ESGE group, 65,6 % for CUME group, and 63,2% ASRM group ($p=0.544$). The LBR was 59,1%, 59,4% and 36,8%, respectively ($p=0.215$). MR occurred in 36,4% (ESHRE/ESGE), 23,8 % (CUME), and 41,7% (ASRM) of patients ($p=0.504$). Although numerically higher rates of clinical pregnancy and live birth were observed in patients diagnosed using ESHRE/ESGE and CUME criteria respectively and higher miscarriage rates in patients diagnosed with ASRM criteria, no statistically significant differences were found among the three groups for the evaluated reproductive outcomes.

Conclusions

The ESHRE/ESGE 2013 diagnostic criteria demonstrate a predictive value for postoperative reproductive outcomes comparable to that of the CUME 2018 and ASRM 2021 classifications for uterine septa.

Unveiling Intrauterine Insights: A Comparative Study of Ultrasound, Hysteroscopy, and Histopathology

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Background

To evaluate the diagnostic accuracy of transvaginal ultrasound (TVUS) for detecting intrauterine pathology, compared with hysteroscopy and histology, aiming to reduce unnecessary invasive procedures in patients investigated for abnormal uterine bleeding (AUB) or other gynaecological concerns.

Methods

This retrospective observational study included patients who underwent hysteroscopy between January 2023 and January 2024 at Whittington hospital, London. All patients received preoperative transvaginal ultrasound (TVUS), followed by hysteroscopic evaluation and, when indicated, operative interventions such as endometrial biopsy, polypectomy, or fibroid resection. Demographic, clinical, and imaging data were collected from electronic medical records. Histological analysis of obtained specimens served as the reference standard

Results

A total of 1,011 women aged 17–92 years (median age 53; mean BMI 28.23) were included. The majority (38.77%) identified as White. The most common indication for hysteroscopy was AUB, including hormone replacement therapy (HRT) -related bleeding (49.55%). A vaginoscopic approach was used in 69.34% of procedures. Hysteroscopy was successfully completed in 97.6% of cases. TVUS identified polyps in 19.77% of cases, fibroids in 39.37%, and adenomyosis in 13.65%, while no abnormalities were reported in 66.86% of patients. Hysteroscopic evaluation diagnosed polyps in 24.80% of women, fibroids in 13.77%, and irregular endometrium in 2.10% of cases. Histological analysis showed polyps in 19.09%, proliferative endometrium in 15.33%, fibroid tissue in 4.65%, endometrial cancer in 1.58%, and atypical hyperplasia in 0.40%, with 28.09% of samples deemed insufficient for diagnosis.

Diagnostic accuracy varied between modalities. For the detection of endometrial polyps, TVUS demonstrated a sensitivity of 39% and a specificity of 83%, while for fibroids, TVUS showed higher sensitivity at 86.96% but lower specificity at 59.93%. Hysteroscopic diagnosis outperformed TVUS in both categories, with a sensitivity of 74.6% and specificity of 87.7% for polyps, and a sensitivity of 89.13% and specificity of 89.89% for fibroids, confirming its superior diagnostic reliability in intrauterine pathology.

Conclusions

TVUS serves as a valuable, non-invasive first-line modality for the evaluation of intrauterine pathology, offering accessibility and ease of use in clinical practice. However, hysteroscopy, with its

capacity for direct visualisation and targeted biopsy or removal of lesions, remains the definitive diagnostic gold standard, particularly when histological confirmation is required. The findings of this study underscore the superior diagnostic accuracy of hysteroscopy compared to TVUS. Nevertheless, ongoing efforts to refine ultrasound criteria and enhance operator training have the potential to improve the sensitivity and specificity of TVUS, thereby reducing unnecessary invasive procedures. Future research should focus on the development of advanced imaging protocols and targeted educational interventions to optimise the diagnostic pathway for women with suspected intrauterine pathology

Transplantation of cryopreserved ovarian tissue in two patients of gynecologic cancers

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Background

To demonstrate the experience of transplantation of cryopreserved ovarian tissue to a sub-peritoneal abdominal site in two patients of gynecologic cancers in our centre.

Methods

The first case was an infertile woman diagnosed as vulvar cancer stage IIIb after radical vulvectomy. To preserve fertility, laparoscopic left ovarian resection and right ovarian suspension was underwent in June 2020. The left ovarian tissue then was preserved by vitrification. But the ovarian function was failure after adjuvant EBRT and six cycles of chemotherapy. Four pieces of ovarian tissue (4/11) were thawed and transplanted to a sub-peritoneal abdominal site above the umbilicus by laparoscopy in December 2023. The second case was a pregnant patient with cervical cancer stage Ib. After four cycles of chemotherapy, caesarean section and radical hysterectomy with ovarian cryopreservation were underwent in September 2018. The ovarian function was failure after EBRT concurrent chemotherapy. Five pieces of ovarian tissue (5/10) were thawed and transplanted to a sub-peritoneal abdominal site above the umbilicus by laparoscopy in January 2024. Ovarian function and ultrasound were monitored every two months post-operation.

Results

Both cases were completed without complications. The ovarian graft function was recovered in the first case with the level of E2 risen to 156 pmol/L after five months of transplantation. While the ovarian graft function was recovered in the second case after six months of transplantation.

Conclusions

Transplantation of cryopreserved ovarian tissue to a sub-peritoneal abdominal site is feasible for the patients in which grafting to pelvic sites is contraindicated.

Application of Autologous Plasma in Asherman's Syndrome

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Background

Intrauterine adhesions, or Asherman's syndrome, is a pathological condition characterized by the formation of intrauterine scar tissue (adhesions) within the uterine cavity, which obstructs normal endometrial growth and leads to impaired reproductive function. Asherman's syndrome is a primary cause of recurrent implantation failure and miscarriage due to poor regeneration of basal endometrial cells. Platelet-rich plasma (PRP) contains numerous growth factors that promote angiogenesis and cellular proliferation. Autologous platelet-enriched plasma may be a promising therapeutic strategy to facilitate angiogenesis and reduce fibrosis in damaged uterine environments, thereby improving embryo implantation success and clinical outcomes in patients with Asherman's syndrome. Objective: To improve the effectiveness of treatment in patients with Asherman's syndrome through intrauterine administration of autologous platelet-rich plasma into the uterine cavity.

Methods

Our institute conducted a research study involving patients with Asherman's syndrome (ESGE classification IIa-Va). The study included 30 women of reproductive age (18-42 years) planning pregnancy either naturally or via assisted reproductive technology (ART). Patient history included previous surgical interventions such as: Myomectomy with uterine cavity opening; Septum resection; Recurrent pregnancy losses (vacuum aspiration; separate diagnostic curettage of the uterine cavity). Group 1 – 15 patients with Asherman's syndrome received hormonal therapy for 3 months after hysteroscopic adhesiolysis. Group 2 – 15 patients with Asherman's syndrome received, immediately after adhesiolysis, intrauterine injection of autologous platelet-rich plasma (10 ml). All patients provided informed consent for participation in this clinical study.

Results

In Group 2, during follow-up office hysteroscopy to assess the extent of adhesions, a reduction in the area and severity of intrauterine adhesions was observed. The adhesions became thinner, more friable, and softer compared to Group 1. Attention was also paid to endometrial thickness. Three months post-treatment: In Group 1: For moderate (IIa-III) severity— 7.2 ± 0.5 mm; for severe (IV-V)— 6.1 ± 0.6 mm. In Group 2: For moderate severity— 7.1 ± 0.9 mm; for severe severity— 6.2 ± 0.9 mm. Statistically significant increases in endometrial thickness were observed after autologous PRP administration.

Conclusions

No adverse effects were noted during or after PRP administration; menstrual function was restored. The study conducted at our institute demonstrates positive results from intrauterine injection of

autologous platelet-rich plasma in patients with Asherman's syndrome. Further long-term follow-up is necessary to evaluate reproductive outcomes and overall efficacy.

A novel strategy to improve surgical field visualization for vNOTES procedures

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Background

Transvaginal Natural Orifice Transluminal Endoscopic Surgery (vNOTES) is increasingly being accepted as the initial minimally invasive technique for benign gynaecological procedures. Difficulty in intraoperative bowel handling and therefore poor visualization of the operative field is an important and underreported barrier with being a possible contributing factor to major complications. Mechanical bowel preparation is no longer suggested, necessitating novel alternatives. We aimed to assess the effects of an approach including a combination of regime of 5-days low fibre diet and complete muscle relaxation with anaesthesia.

Methods

This two-centred prospectively designed retrospective study included a total of 253 eligible patients who underwent either hysterectomy or adnexal vNOTES procedures for benign conditions. Patients were sequentially enrolled from January 2022 to May 2025 at two tertiary centres. Patients were divided into two groups as follows: (i) no preoperative diet restriction and standardized general anaesthesia approach, (ii) preoperative 5-days low fibre diet and anaesthesia team maintained the complete clinical relaxation (Grade 4) all through the operation by continuous infusion of neuromuscular blocking agent administration. Primary outcomes were modified objective visual index (OVI) to assess the visualization of the surgical field, operation time and subjective assessment of patients' comfort and compliance with Quality of Recovery-15 scale (QoR-15T).

Results

Age (46,01±8,81 vs. 45,13±9,36, p=.442), BMI (29,83±6,52 vs. 29,17±5,32, p=.412), number of previous abdominal surgery (1(2) vs. 0(1), p=.069) and postoperative hospitalization duration (18,72±4,22 vs. 19,05±4,36 hours, p=.542) were similar among groups. OVI index scoring was significantly improved (Median:2 (IQR:0) vs 1(0), p<.001) and operation time was significantly reduced (64,20±42,08 vs. 80,72±59,93 mins, p<.001) in patients with preoperative diet and achieving intraoperative complete relaxation with continuous neuromuscular blockage when compared to no diet restrictions and regular intraoperative anaesthesia management. This trend was found to be same when the analysis was repeated separately in adnexal surgeries (OVI score: 2(0) vs. 1(0), p<.001 and Operation time: 14,73±3,69 vs. 29,24±24,54 mins, p<.001) and hysterectomies (OVI score: 2(0) vs. 1(0), p<.001 and Operation time: 87,51±34,52 vs 110,72±48,21 mins, p<.001). Subjective assessment of quality of recovery was found to be similar among groups (p<.05). There were 2 and 1 bladder perforation in the study and control group, respectively. One bowel thermal injury was observed in one vNOTES hysterectomy patient without preoperative diet and regular intraoperative anaesthesia management. That case was managed with intraoperatively suturing and close follow-

up. No conversion to laparoscopy or laparotomy was observed in all patients. Uterus weight was heavier in the study group among vNOTES hysterectomy patients ($379,82 \pm 259,09$ vs. $211,72 \pm 101,13$ -gram $p < .001$).

Conclusions

Implementing a combination of preoperative 5-days low-fibre diet and intraoperative complete muscle relaxation with continuous infusion of neuromuscular blocking agent significantly improved the visualization of surgical field and reduced the operation time in both vNOTES adnexal and hysterectomy procedures.

Understanding the concept of interference in vNOTES surgery, classification and analysis and demonstration of patterns

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Background

This is to analyse the intraoperative elements when the progress or the flow of surgical steps was slowed, interrupted or stopped due to the lack of information or loss of information in vNOTES surgery. This is because of an organ blocking or **interfering** in the visual assessment to progress safely to the next steps. The interference required the surgeon to stop, assess and take additional steps then to assess again. This study was interested mainly in identifying patterns and reasons and coding them and understand their importance, applications and suggestion for management.

Methods

In doing the analysis 100 cases of successfully concluded vNOTES hysterectomies done in Epsom Hospital from 2023 to 2024, performed by one surgeon with standardised setting. The video recordings of the cases were reviewed with the focus on when the progress was slowed down because of interference. The cases were done for oncological indications after process them the multidisciplinary team meeting, for endometrial neoplasia, cervical neoplasia, adnexa mass suspicious of early cancer, fibroids, and some benign cases of adenomyosis and prolapse. The mean age range 61y (+/-12), 50% had BMI > 30 and 20% had previous caesarean section. The average operating time was 151 minutes (+/-62min). The interference in this series observed in 60% of cases given the high-risk comorbidities in the case series. For this instance, the focus was on the laparoscopic phase of the vNOTES. The average intraoperative pressure was 10mmHg with little variation and all the cases were performed with 3D laparoscopy and using Gel points advanced platform and Voyant energy device. 75% of cases had spinal regional anaesthesia part of the local protocol. Therefore, the interference was attributed to intra operative phenomenon related to anatomical reasons but not due to surgical performance, technique, or devices.

Results

The following observations were made. The interference can be

1-a fixed phenomenon and this named a 'blind spot'. This is where there is no information from the start due to lack of mobility of the interfering organ.

2-a dynamic phenomenon and this is termed 'harassment'. This is because of loss of information due to the mobility of the organ.

The following types were noticed

- 1- Cervical interference
- 2- Uterine interference
- 3- Bowel interference
- 4- Bladder interference

There can be more than one type of interference and this was noticed to cause prolongation of the operative time and required extra steps to overcome the difficulty. In some cases, the interference

was associated with intraoperative complication. Some surgical algorithms appeared to resolve the difficulty faster than other manoeuvres and hence made the operative more efficient.

Conclusions

This is an attempt to standardise and code intra operative findings in vNOTES that can reduce the efficiency. This will require further validation and agreement with potential application in training the technique.

Operative time and difficult cases in vaginally assisted NOTES hysterectomy

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Background

Vaginally assisted NOTES hysterectomy (VANH) is a minimally invasive surgical approach. However, its introduction in Japan is relatively recent, and limited clinical experience may hinder accurate preoperative prediction of operative time. This study aimed to retrospectively investigate factors influencing operative time in VANH.

Methods

We retrospectively reviewed VANH procedures performed at our institution between July 2022 and March 2025. Cases involving concurrent procedures such as ovarian cystectomy or planned hybrid approaches were excluded. Operative time was log-transformed and analysed using multivariable linear regression. Independent variables included patient demographics, fibroid location, surgeon, presence of adhesions or endometriosis, and specimen weight. Statistical significance was defined as $p < 0.05$. We defined prolonged cases as those exceeding the mean log-transformed operative time by more than two standard deviations (approximately ≥ 123 minutes). Additionally, cases requiring laparoscopic assistance were evaluated separately as technically demanding cases.

Results

A total of 210 patients were included. The median age, BMI, blood loss, operative time, and specimen weight were 47 (30–72) years, 21.7 (16.3–34.4) kg/m², 30 (0–800) mL, 56.5 (22.0–171.0) minutes, and 186.5 (24.0–995.0) g, respectively. Multivariable analysis identified BMI, the presence of anterior wall or broad ligament fibroids, and specimen weight as significant predictors of operative time. Seven cases met the criteria for prolonged operative time. Compared to the overall group, these cases had a higher median BMI (23.2 kg/m² vs. 21.7 kg/m²) and specimen weight (254 g vs. 186.5 g). Among them, four cases involved fibroids ≥ 5 cm located on the anterior wall or within the broad ligament. Of the four cases requiring laparoscopic assistance, three involved laparoscopic observation via the umbilicus due to difficulty in dissecting the vesicouterine pouch. One case, complicated by endometriotic adhesions in the pouch of Douglas, required conversion to laparoscopy due to uncontrolled bleeding during vaginal wall closure. In one patient, a bladder injury occurred in the setting of prior cervical cerclage.

Conclusions

Operative time in VANH was associated with BMI, the presence of anterior wall or broad ligament fibroids, and specimen weight. Fibroids ≥ 5 cm in these locations may hinder visualization and manoeuvrability, contributing to prolonged operative time. A comprehensive risk assessment, including the evaluation of fibroid location and the presence of adhesions, is essential for planning the appropriate surgical approach.

Management of a Large Uterus via Posterior Colpotomy in v-NOTES Following Anterior Access Failure

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Background

v-NOTES (transvaginal natural orifice transluminal endoscopic surgery) is an evolving minimally invasive technique that allows abdominal surgeries to be performed through the vaginal route, avoiding visible scars and reducing postoperative recovery time. It is advantageous in patients with large uterus and favourable anatomy, such as those with prior vaginal deliveries and no history of abdominal surgery.

Methods

We present the case of a 46-year-old woman with a history of three spontaneous vaginal deliveries and no prior abdominal surgeries, who was admitted with persistent and significant abdominal pain. Transvaginal ultrasonography revealed multiple uterine fibroids, the largest measuring 83 × 74 mm. On pelvic examination, second-degree anterior and posterior compartment prolapse and stress urinary incontinence were noted. A v-NOTES hysterectomy combined with bilateral salpingectomy and a trans obturator tape (TOT) procedure was planned. The procedure began with identification of cervical boundaries, followed by a posterior colpotomy created approximately 1 cm below the cervix. Due to the enlarged and laterally displaced uterus, anterior colpotomy could not be performed at this stage. Dissection was directed toward the lateral pelvic window by identifying the reflective area created by intraperitoneal CO₂ insufflation. After accessing the lateral window, anterior colpotomy was successfully performed. Following completion of the anterior colpotomy, the Alexis port was reinserted, and a standard hysterectomy was performed on the myomatous uterus.

Results

The v-NOTES operation lasted 74 minutes. No intraoperative or postoperative complications were observed. The pathology report confirmed a uterus weighing 482 grams and measuring 16 × 12 × 8 cm, containing 13 uterine fibroids. The patient was discharged in good health on postoperative day one.

Conclusions

v-NOTES hysterectomy is a safe and effective approach in well-selected patients. This case highlights that without an initial anterior colpotomy, the natural orifice route ensures excellent visualization, access, and fast recovery, even in the presence of a large myomatous uterus.

<https://player.vimeo.com/video/1089866418?autoplay=1>

Pushing the Boundaries of vNOTES: Complex Cases Presentations with tips for surgical success

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Background

Vaginal Natural Orifice Transluminal Endoscopic Surgery (vNOTES) has revolutionized minimally invasive Gynecologic surgery by combining the benefits of vaginal access with laparoscopic visualization. While increasingly accepted for routine hysterectomies, its application in complex surgical scenarios remains less explored. This study presents a series of challenging vNOTES hysterectomy cases, aiming to highlight the procedural feasibility and share actionable surgical strategies that contribute to successful outcomes.

Methods

We conducted a retrospective analysis of complex vNOTES hysterectomies performed between January 2023 and March 2025. Cases were classified as complex based on factors such as significant uterine enlargement (>500g), body mass index more than 40 kg/m², history of pelvic or abdominal surgeries, advanced endometriosis, adnexal pathology, or altered pelvic anatomy. Operative parameters included procedure duration, blood loss, complications, and length of hospital stay. Detailed intraoperative techniques were documented to develop a set of practical tips for navigating surgical challenges.

Results

Thirty-five patients underwent complex vNOTES hysterectomy during the study period. The mean uterine weight was 850g, ranging from 520g to 2400g. Seventy five percent of patients had a history of prior pelvic surgery, and 30% were diagnosed with stage III or IV endometriosis. Notably, 7 patients (20%) had a BMI greater than 40 kg/m², presenting an additional technical challenge. The average operative time was 105 minutes (range: 65–135 minutes), with an estimated mean blood loss of 90 mL. No conversions to laparotomy or conventional laparoscopy were required. Two patients experienced minor postoperative complications (urinary retention and low-grade fever), with all patients discharged within 24 hours. Surgical challenges included limited working space, dense adhesions, and anatomical distortion. Key intraoperative strategies for overcoming these difficulties included early identification of critical structures through optimized port and patient positioning and development of avascular spaces with lateral approach to surrounding pelvic organs.

Conclusions

This case series demonstrates that vNOTES hysterectomy can be safely extended to complex surgical scenarios with careful planning, surgeon experience, and specific technical adaptations. The outlined strategies provide a practical guide to overcoming anatomical and procedural challenges, offering a roadmap for expanding the role of vNOTES in advanced Gynecologic surgery. These insights may support broader implementation of vNOTES techniques and enhance surgical confidence in managing difficult cases.

vNOTES for large ovarian cyst by using S.A.N.D Ballon catheter

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Background

To evaluate the feasibility and safety of the S.A.N.D. balloon catheter for transvaginal natural orifice transluminal endoscopic surgery (vNOTES) in the management of large ovarian cysts.

Methods

We report on six cases of vNOTES for large ovarian cysts (13–17cm) using the S.A.N.D. balloon catheter, a device developed in Japan with two independently inflatable balloons at the tip. This design enables effective immobilization of the cyst wall and controlled aspiration of internal fluid, facilitating cyst size reduction. The technique allowed for cyst decompression and safer retrieval through vaginal access. Detailed descriptions of two representative cases—a 14cm serous ovarian cyst (with bilateral salpingo-oophorectomy) and a 15cm dermoid cyst (with cystectomy and ovarian suturing)—are provided.

Results

All cases involved cysts too large to be removed directly through the vaginal route due to their upper abdominal location and size. In each, the S.A.N.D. balloon catheter stabilized the cyst wall and allowed for stepwise aspiration of contents, significantly reducing size and enabling vaginal retrieval in an extraction bag. In the described cases, aspirated cysts weighing about 1kg (serous) and 1.2Kg (dermoid) were successfully removed with no intraoperative complications. Across six cases, the technique proved effective regardless of cyst histology, although the ease of aspiration depended on the fluid's viscosity.

Conclusions

The S.A.N.D. balloon catheter is a valuable tool for vNOTES in large ovarian cysts, improving safety and feasibility by enabling controlled decompression and easy vaginal extraction. Although performance may vary with cyst content characteristics, this technique expands vNOTES indications for ovarian masses previously considered unsuitable for vaginal removal.

<https://player.vimeo.com/video/1085837603?autoplay=1>

Challenging vaginal access in VNOTES hysterectomy: anterior endoscopic peritoneal opening as a strategy for success.

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Background

To analyse intraoperative and postoperative complications in VNOTES hysterectomies and assess the impact of implementing anterior endoscopic peritoneal opening on reducing complications, especially bladder injuries, in cases with difficult vaginal access.

Methods

A retrospective review of 94 VNOTES hysterectomies performed between 2021 and 2024 was conducted, excluding oncologic cases and unilateral adnexectomies. Complications were classified as intraoperative or postoperative. In mid-2022, anterior colpotomy with endoscopic visualization was implemented selectively for cases with anticipated difficult vaginal access. Data were analysed regarding complication rates, type of access (direct vaginal vs. endoscopic anterior), conversion rates, and patient characteristics including uterine size and prior surgeries.

Results

Out of 94 patients, 10 (10.6%) experienced complications: 7 intraoperative (7.4%) and 3 postoperative (3.2%). Intraoperative complications included 5 bladder injuries (1 repaired laparoscopically after conversion, 4 vaginal repairs), 1 rectal injury (laparoscopic repair after conversion), and 1 bleeding event requiring conversion. Postoperative complications included 1 ureteral injury (Clavien-Dindo IIIb), 1 vesical fistula (Clavien-Dindo IIIa), and 1 abscess (Clavien-Dindo II). The overall conversion rate was 2.82%.

Among bladder injuries, 80% occurred during direct vaginal anterior colpotomy access. Of all complications, 44% happened in patients with endoscopic anterior colpotomy access and 56% with direct vaginal access. Intraoperative complication rates were lower in the endoscopic group (33%) compared to the vaginal group (66%). Patients with complications had larger uteri (>16 weeks gestational size, mean weight 642 g). The implementation of anterior endoscopic peritoneal opening correlated with a reduction in bladder injuries and conversions, facilitating safer access in complex cases.

Conclusions

Difficult vaginal access remains a significant challenge in VNOTES hysterectomy. Our data suggest that the selective use of anterior endoscopic peritoneal opening during colpotomy improves surgical safety by reducing bladder injuries and conversion rates. Recognizing risk factors preoperatively and incorporating this technique are essential steps in advancing the learning curve and expanding VNOTES applicability in complex pelvic surgeries.

Turkish Nationwide vNOTES Experience Between 2016–2025: A Multicenter Report of 3620 Cases by the vNOTES-TR Study Group

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Background

To evaluate the nationwide experience of transvaginal natural orifice transluminal endoscopic surgery (vNOTES) across Türkiye from 2016 to 2025, with a focus on surgical indications, complication rates, and conversion rates in a large multicenter cohort.

Methods

A retrospective observational study was conducted by the vNOTES-TR Study Group, collecting anonymized data from 25 tertiary centres across Türkiye. Between 2016 and 2025, a total of 3620 patients underwent various vNOTES procedures. Surgical indications included adnexal pathologies, hysterectomy, uterine prolapse, myomectomy, and endometrial cancer. Complication types and frequencies were recorded, along with conversion rates to laparotomy or laparoscopy. Data were analysed using descriptive statistics.

Results

Among 3620 patients, the most frequent indication for vNOTES was adnexal surgery (n=1995, 55%), followed by prolapse repair (n=765, 21.1%), hysterectomy (n=716, 19.7%), endometrial cancer surgery (n=115, 3.1%), and myomectomy (n=29, 0.8%). Major complications occurred in 71 cases (1.9%). The most common complications included bladder injury (n=32, 0.8%), bowel injury (n=16, 0.4%), ureteral injury (n=3, 0.08%), and need for blood transfusion (n=20, 0.5%). One case of extremity nerve injury (0.02%) was reported. Conversion to laparotomy occurred in 8 cases (0.2%), while 22 procedures (0.6%) required conversion to laparoscopy.

Conclusions

This study represents the largest national vNOTES dataset to date and demonstrates that vNOTES is a feasible and safe approach for a wide range of Gynecologic procedures when performed by experienced surgeons. The low rates of major complications and conversions support the adoption of vNOTES as a minimally invasive option within advanced Gynecologic surgery. Continued multicenter collaboration will be essential to refine indications, optimize outcomes, and guide training strategies for wider implementation.

Effectiveness of Perioperative Duloxetine for Pain Management in vNOTES Hysterectomy: A Randomized, Placebo-Controlled Trial

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Background

Transvaginal natural orifice transluminal endoscopic surgery (vNOTES) can be utilized as a "rescue" technique during vaginal procedures, relying on fundamental laparoscopic single-site skills to address and resolve these challenges. Duloxetine hydrochloride is a potent serotonin and noradrenaline reuptake inhibitor, known for its balanced mechanism of action. Studies suggest its role in enhancing postoperative recovery and managing acute pain after surgeries, including knee replacements, mastectomies, spinal surgeries, and major abdominal cancer operations. Its mood-enhancing properties may further improve recovery outcomes during healing. However, the effectiveness of duloxetine as a premedication for laparoscopic or open hysterectomy remains debated. A recent meta-analysis underscores the importance of high-quality research in this area. This study aims to evaluate the impact of perioperative administration of duloxetine on postoperative pain management and recovery quality in women undergoing vNOTES total hysterectomy. (NCT06429605)

Methods

Conducted as a randomized controlled trial, the study involved 76 women divided into two groups—39 in the study group and 37 in the control group. Patients in the study group received 60 mg of oral duloxetine 2 hours prior to surgery and again 24 hours post-surgery, whereas those in the control group were given a placebo following the same schedule. While medical staff were aware of the treatment allocations, all patients remained blinded to the type of medication administered

Results

No differences were observed between the patients in terms of baseline demographics or perioperative characteristics. Eight hours after surgery, the study group demonstrated a significantly lower mean visual analog scale (VAS) pain score compared to the control group (4.4 ± 0.7 vs. 3.7 ± 1.0 , $P = 0.002$). Additionally, the mean VAS scores at 4-, 12-, and 24-hours post-surgery were also significantly lower in the study group. The mean scores on the faces pain scale-revised consistently showed reductions in the study group as well. A smaller proportion of patients in the duloxetine group required rescue analgesics (25.6% versus 45.9%, $P = 0.033$). Women treated with duloxetine attained significantly higher scores on the overall QoR-15 questionnaire (111.4 ± 5.0 vs. 104.8 ± 5.5 , $P < 0.001$). No notable differences in adverse outcomes were observed between the duloxetine and placebo groups (Table 1).

Conclusions

Administering duloxetine as premedication for patients undergoing V-notes hysterectomy is a safe and effective approach to minimizing postoperative pain, reducing the need for additional analgesics, and enhancing patient satisfaction. Therefore, this strategy can be incorporated into an enhanced recovery protocol.

Insights and pearls for uterosacral suspension in vNOTES hysterectomy

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Background

Vaginal natural orifice transluminal endoscopic surgery (vNOTES) is an emerging minimally invasive technique that provides laparoscopic access via the transvaginal route. Unlike conventional laparoscopic or robotic hysterectomy, vNOTES involves routine early transection of the uterosacral ligaments—key structures in maintaining apical vaginal support. This raises concerns regarding future pelvic organ prolapse. The aim of this study is to describe a technique for prophylactic uterosacral suspension during vNOTES hysterectomy to preserve apical support and align with pelvic reconstructive principles and ACOG guidelines.

Methods

A detailed intraoperative video tutorial demonstrates the uterosacral suspension technique performed during a vNOTES hysterectomy in a 51-year-old woman (G4P2) with a history of cervical dysplasia and prior vaginal deliveries. Following completion of the standard vNOTES hysterectomy and bilateral salpingectomy, a prophylactic uterosacral ligament suspension was performed to mitigate the risk of future apical prolapse. The video highlights essential surgical steps, including identification of key anatomical landmarks, suture placement, and tissue handling techniques. Technical pearls and safety considerations are emphasized throughout to guide optimal execution and enhance procedural confidence.

Results

The uterosacral suspension technique was successfully implemented without intraoperative complications. The video demonstrates that the approach is both feasible and effective in preserving apical support following vNOTES hysterectomy. This intervention is consistent with ACOG guidelines, which recommend incorporating apical support at the time of hysterectomy to reduce the risk of future prolapse. While long-term outcome data are still pending, early experience supports its integration into standard surgical practice.

Conclusions

As adoption of vNOTES increases, attention to long-term outcomes, including pelvic organ support, becomes essential. Integrating uterosacral suspension as a routine component of vNOTES hysterectomy may mitigate the risk of future prolapse, uphold surgical best practices, and enhance long-term patient outcomes.

<https://player.vimeo.com/video/1082637710?autoplay=1>

Cost-effectiveness of robotic vs. laparoscopic-assisted Vaginal Natural Orifice Transluminal Surgery (vNOTES) for Hysterectomy

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Background

The primary criticism of robotic vaginal natural orifice transluminal endoscopic surgery (vNOTES) is its potential additional cost compared to conventional laparoscopy. This study aims to compare the operative characteristics and costs of robotic versus laparoscopic vNOTES.

Methods

This is a retrospective study that was conducted at a single tertiary medical centre including 72 women who underwent vaginal natural orifice transluminal endoscopic surgery (vNOTES) hysterectomy. Patients were divided into two groups based on the surgical approach: the study group underwent robot-assisted laparoscopy, while the control group underwent conventional laparoscopy. Both groups were evaluated for operative characteristics and surgery-specific costs to compare the outcomes of the two techniques. Shared equipment costs used across both groups were excluded from the analysis. The primary outcome was the total cost per procedure, incorporating the cost of approach-specific equipment and procedure duration. Both groups were evaluated for operative characteristics and surgery-specific costs to compare the outcomes of the two techniques. Shared equipment costs used across both groups were excluded from the analysis. The primary outcome was the total cost per procedure, incorporating the cost of approach-specific equipment and procedure duration.

Results

Of the 72 women included in the study, 35 (49%) underwent robotic vNOTES and 37 (51%) underwent conventional laparoscopic vNOTES. Baseline characteristics, including age, body mass index (BMI), parity, and history of caesarean deliveries, were comparable between the two groups. In both groups, the most common indication for surgery was symptomatic fibroids causing abnormal uterine bleeding. Specimen weights were similar between groups [200 g (range 97–290) vs. 218 g (range 90–358); $p = 0.93$].

Procedure duration, measured from intubation to extubation, was slightly shorter in the robotic group, with a median time of 114 minutes (range 91–134) compared to 129 minutes (range 100–152) in the laparoscopic group, although this difference was not statistically significant ($p = 0.15$). Cost analysis was performed for each case, incorporating the cost of procedure-specific equipment and operative time. Operative time was monetized at a standard institutional rate of \$57.76 per minute, which included operating room, anaesthesia, and surgeon fees. The total cost of robotic vNOTES was calculated at \$8,559.09, compared to \$7,753.19 for laparoscopic vNOTES. The difference in total cost between the two approaches was not statistically significant ($p = 0.32$).

Conclusions

Robotic vNOTES is comparable in cost to laparoscopic vNOTES, considering both equipment and total procedure time. This suggests that robotic vNOTES is not significantly more expensive than laparoscopic vNOTES.

özen colpotomizer

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Background

Minimally invasive gynaecologic procedures such as laparoscopic hysterectomy require both precise manipulation of the uterus and safe execution of circular incision and suturing at the cervical-vaginal junction. Conventional manipulators often require multiple instruments and steps, leading to increased procedural complexity and risk of intraoperative complications.

Methods

In this study, we present a novel uterus manipulator specifically designed for laparoscopic hysterectomy, integrating both suturing and incising mechanisms into a single, compact system. The manipulator enables pre-incision suturing of the cervical-vaginal tissue followed by a controlled circular incision, effectively reducing the risks of bleeding, hematoma, and tissue trauma. The device's ergonomic handle provides intuitive push-pull operation, ensuring seamless transition between suturing and cutting without the need for instrument change or repositioning.

Key structural components include a rotating head with a stabilizing ring, a spring-loaded needle housed within a suturing track, and a gear-driven blade system for circular colpotomy. The manipulator also allows for dual-plane uterine movement, improving surgical visibility and access in confined anatomical regions.

Results

This integrated solution simplifies the surgical workflow, minimizes intraoperative risks, and enhances precision during the most critical phases of laparoscopic hysterectomy. Its compact design and reliable mechanical action make it a promising innovation for safer and more efficient gynaecologic surgeries.

Conclusions

This integrated solution simplifies the surgical workflow, minimizes intraoperative risks, and enhances precision during the most critical phases of laparoscopic hysterectomy. Its compact design and reliable mechanical action make it a promising innovation for safer and more efficient gynaecologic surgeries.

<https://player.vimeo.com/video/1090246794?autoplay=1>

Does Sparing the Round Ligament Protect the Ovaries? A Prospective Study on Vascular Preservation during Hysterectomy

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Background

Hysterectomy is a common surgical procedure among premenopausal women, but its potential impact on ovarian function remains a matter of concern. Disruption of the utero-ovarian vascular axis is considered a major contributor to postoperative ovarian dysfunction. The round ligament, often overlooked, contains vascular structures including the Sampson artery, which may serve as a collateral route for ovarian perfusion. This study aimed to evaluate whether preserving the vascular integrity of the round ligament during hysterectomy helps maintain ovarian hormonal function.

Methods

This prospective, randomized controlled trial included 60 premenopausal women undergoing hysterectomy for benign indications at a tertiary university hospital between April 2022 and February 2023. Participants were randomly assigned to the study group, in which round ligament vascularization was preserved, or the control group, in which the ligament was transected. Serum levels of FSH, LH, and estradiol were measured before surgery and at 3 months postoperatively. Randomization was performed using computer-generated sequences, and ethical approval was obtained from the Clinical Research Ethics Committee of Uludağ University.

Results

Sixty premenopausal women were equally assigned to the study and control groups, with no significant differences in baseline demographic or hormonal parameters. Three months after surgery, both groups demonstrated significant increases in serum FSH and LH. However, estradiol levels remained stable in the study group ($p=0.299$), whereas a significant decline was observed in the control group ($p=0.049$). Although intergroup differences in the percentage change of hormone levels did not reach statistical significance (estradiol $p=0.067$), the observed trend suggested improved preservation of ovarian function in the round ligament-sparing group. Surgical approach (TAH vs. TLH) had no measurable effect on endocrine outcomes.

Conclusions

This study provides preliminary evidence that preserving round ligament vascularization during hysterectomy may contribute to better maintenance of ovarian hormonal function in premenopausal women. While no statistically significant intergroup differences were observed, the trend toward more favourable estradiol stability in the study group is biologically plausible and supports the hypothesis of a collateral vascular role. These findings offer a novel perspective on a routinely transected anatomical structure and underscore the potential relevance of vascular-preserving

techniques in gynaecologic surgery. Given the limited sample size and short-term follow-up, further research with larger cohorts and extended endocrine evaluation is necessary to clarify the clinical significance and generalizability of these observations.

Neuropelviology

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Background

To demonstrate the surgical anatomy of pelvic nerves.

Methods

The supraumbilical optic port is used to gain exposure in the pelvic cavity.

Results

There are autonomic and somatic nerves. Autonomic nerves are responsible for the innervation and function of the bladder, uterus, and rectum, with the terminal branches. The superior hypogastric plexus is formed by the extensions of the thoracolumbar splanchnic nerves and is located at the caudal part of the inferior mesenteric artery, anterior to the aortic bifurcation. The extensions of the superior hypogastric plexus form the hypogastric nerve at the anterolateral part of the sacrum, within the retrorectal space, while the hypogastric nerve lies at the medial pararectal space. These branches provide sympathetic innervation. The pelvic splanchnic nerves originate from the Sacral 2-4 vertebra level at the dorsolateral part of the pararectal space and run obliquely towards the medial Para cervix, delivering parasympathetic innervation. The hypogastric and pelvic splanchnic nerves merge and form the inferior hypogastric plexus at the caudal part of the medial pararectal space, which has both sympathetic and parasympathetic branches. Somatic nerves travel through the pelvis, supplying motor and/or sensory innervation. The obturator nerve (Lumbar 2-4) is located at the lateral Para vesical space within the obturator lymph nodes and is responsible for maintaining leg adduction. The genitofemoral nerve (Lumbar 1-2) lies lateral to the external iliac artery, superior to the psoas major muscle. The lateral femoral cutaneous nerve (Lumbar 2-3) is positioned at the superior part of the iliacus muscle. The lumbosacral trunk (Lumbar 4-5) is located at the later vascular plane, inferior to the obturator nerve and lateral to the internal iliac vein, contributing to the formation of the sciatic nerve.

Conclusions

Orientation to the topographic anatomy of the pelvic nerves with the avascular spaces and neighbouring anatomical structures is crucial to prevent nerve injury during pelvic surgery.

<https://player.vimeo.com/video/1090242036?autoplay=1>

Laparoscopic Hysterectomy in a Patient with Severe Adhesions and a Large Adenomyotic Uterus: A Case Demonstrating Surgical Precision and Risk Management

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Background

To present a complex case of total laparoscopic hysterectomy with bilateral salpingo-oophorectomy in a patient with a large, adenomyotic uterus and extensive pelvic adhesions, highlighting the surgical techniques used to safely manage anatomical challenges and prevent instrument-related complications

Methods

A 47-year-old patient with complaints of treatment-resistant abnormal uterine bleeding was admitted to our clinic and taken for further evaluation. The patient has no known comorbidities. She has a history of laparoscopic surgery due to uterine myoma and endometrioma. Although she previously used oral contraceptives, she is not currently on any medication.

Her Pap smear and endometrial biopsy, performed due to abnormal uterine bleeding, revealed no pathological findings. MRI showed minimal endometrioma foci in both ovaries, an enlarged uterus due to adenomyosis, and multiple fibroids—the largest measuring 3.5 x 3.5 cm. Additionally, a lesion requiring histopathological confirmation was described in the endocervical area. Based on these findings, the patient was scheduled for total laparoscopic hysterectomy with bilateral salpingo-oophorectomy and frozen section analysis.

During surgery, in addition to widespread intra-abdominal adhesions, multiple endometriotic foci were observed, the largest of which was on the uterosacral ligament. After adhesiolysis and the beginning of the hysterectomy, one of the instruments broke during colpotomy. The broken tip and the instrument were safely retrieved from the abdominal cavity, as shown in the video.

Subsequently, the uterus and adnexa were sent for frozen section without disrupting their integrity. Since malignancy was not suspected based on the frozen section, the operation continued with excision of the nodule on the uterosacral ligament. The vaginal cuff was then closed, and the uterosacral ligament was sutured and reinforced.

Results

During the approximately 2-hour-long operation, no adverse events such as bleeding, ureter injury, or harm to the patient due to the broken instrument occurred. The patient did not report any complaints during postoperative follow-up in the ward or at her first postoperative check-up.

Conclusions

This case serves as a valuable demonstration, both in terms of performing a hysterectomy on a large uterus with adhesions to surrounding tissues via a laparoscopic approach—which requires laparoscopic expertise to skeletonize and expose critical anatomical structures such as the ureter and

uterine artery—and in terms of preventing potential complications that could arise from the surgical instruments used during the procedure This case serves as a valuable demonstration, both in terms of performing a hysterectomy on a large uterus with adhesions to surrounding tissues via a laparoscopic approach—which requires laparoscopic expertise to skeletonize and expose critical anatomical structures such as the ureter and uterine artery—and in terms of preventing potential complications that could arise from the surgical instruments used during the procedure

<https://player.vimeo.com/video/1090194245?autoplay=1>

An unusual case of severe bowel adhesions during laparoscopic hysterectomy; should previous uterine artery embolisation be consider as a risk factor during surgical planning?

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Background

Aim

To present a case with unexpected dense bowel adhesions in the absence of previous abdominal surgery, secondary to previous uterine artery embolization

Case

60-year-old patient, nulliparous, not on HRT presented with post-menopausal bleeding on three different occasions. Diagnostic hysteroscopies and endometrial biopsies excluded pre-malignant and malignant causes however the patient chose definitive management. Therefore, was listed for an elective total laparoscopic hysterectomy with bilateral salpingo-oophorectomy.

Methods

The procedure started as a standard setting operative laparoscopy with a 10mm umbilical port and two 5mm lateral auxiliary ports. Due to the complexity of the case an extra 5mm supra-pubic port was added. For dissection we used a combination of cold scissors, ultrasonic energy device and bipolar. We started by dividing adhesions between the sigmoid colon, the posterior uterine wall and the left pelvic side wall. We followed by mobilising the sigmoid colon to allow access for the left gonadal vessels and for a safe oophorectomy. The left broad ligament was opened and after identifying the left ureter we prepared the space before sealing the uterine vessels. After following the same steps on the right side of pelvis, we were left with extremely dense adhesions between the rectosigmoid and the posterior uterine wall. During this dissection, the uterine wall suddenly opened and calcified plaques spread in the pelvis. We completed the total hysterectomy after ensuring that no residual calcified material was left in.

Results

The total blood loss was 300mls, the patient was discharged the following day and had an uncomplicated recovery. The histopathology results showed benign cells with calcified areas within the myometrium.

Conclusions

Previous uterine artery embolisation (UAE) can cause significant adhesions due to the inflammatory process secondary to fibroid degeneration. Pre-operative planning should include UAE as a risk factor.

<https://player.vimeo.com/video/1085846011?autoplay=1>

Advanced laparoscopic dissection of pelvic sidewall and sciatic nerve in stage II endometrial carcinoma: an anatomically focused surgical video

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Background

Retroperitoneal pelvic side wall dissection is extremely important in deep infiltrative endometriosis surgery and oncological surgery. It is important to dissect and identify important anatomical structures before performing retroperitoneal lymph node dissection in oncological surgery or before performing excision in cases of deep infiltrating endometriosis surgery with significant nerve involvement such as the sciatic nerve.

Methods

To provide a detailed laparoscopic demonstration of pelvic sidewall and sciatic nerve dissection in a patient undergoing radical oncologic surgery for stage II endometrial carcinoma, with a focus on the integration of gynaecologic oncologic and Neuropelviology principles

Results

The total operative time was 140 minutes. Estimated intraoperative blood loss was 100 mL, and no blood transfusion was required. No intraoperative or postoperative complications occurred. R0 resection was achieved. The video provides clear visualization of all major anatomical compartments, allowing for precise orientation and safe surgical execution.

Conclusions

This surgical video offers a comprehensive anatomical reference for laparoscopic dissection of the pelvic sidewall and sciatic nerve. By integrating principles of gynaecologic oncology and Neuropelviology, it serves as an advanced educational tool to promote surgical safety, enhance anatomical understanding, and support nerve-sparing techniques in minimally invasive radical gynaecologic procedures.

<https://player.vimeo.com/video/1085833335?autoplay=1>

Laparoscopic Sciatic Nerve Dissection: a Reproducible Approach

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Background

To present the anatomical landmarks of a standardized and reproducible surgical approach enabling laparoscopic sciatic nerve dissection utilising the "medial" approach.

Methods

Narrated surgical video. Local institutional review board not required, patient consent was obtained. The sciatic nerve can be compressed by several gynaecological and obstetrical causes leading to sciatica, with endometriosis being the commonest gynaecological aetiology. Sciatic nerve dissection can be performed laparoscopically via a "lateral" or a "medial" approach. The "lateral" approach utilises a plane of dissection lateral to external iliac vessels, whereas, in the "medial" approach, the surgeon dissects medially to the external iliac vessels. 28-year-old patient with chronic pelvic pain radiating to the posterior aspect of her right lower limb. Pre-operative imaging did not identify any pathology accounting for her symptomatology, however, due to the severity of symptoms, an exploratory laparoscopy was decided upon.

Results

Laparoscopic sciatic nerve dissection utilising the "medial" approach can be performed by following these steps: 1. Horizontal incision of the peritoneum, parallel to the gonadal vessels, in the triangle that is formed by the adnexa, the external iliac vessels and the round ligament. 2. Identification of the ureter that is kept on the medial border of the dissection plane. 3. Identification of the obturator nerve and vessels laterally. 4. Deepening the dissection caudally, to reach the hypogastric vein. Careful skeletonization of this vessel is necessary to avoid haemorrhage. 5. Fine dissection lateral and caudal to the hypogastric vein leads to the identification of the lumbosacral trunk and sciatic nerve.

Conclusions

The "medial" approach described here represents a safe and standardized approach to dissect the sciatic nerve laparoscopically, employing a dissection plane medial to the external iliac vessels.

<https://player.vimeo.com/video/1085650679?autoplay=1>

Laparoscopic Identification of the Inferior Hypogastric Nerve for the Gynaecologist

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Background

To demonstrate how to identify and preserve the inferior hypogastric nerve during gynaecological laparoscopic surgeries, in cases where the nerve is not infiltrated by pathological processes such as deep endometriosis. The inferior hypogastric nerve is liable to injury during gynaecological surgery, which may lead to vaginal and cervical hypoesthesia, diminished vaginal lubrication, urinary retention or anorectal dysfunction.

Methods

Narrated surgical video. Institutional Board Review approval not required, patient consent obtained. 40-year-old patient with chronic pelvic pain. Imaging suggested the presence of a 4-centimeter right haemorrhagic cyst. No evidence of deep endometriosis was detected on imaging or laparoscopy. Excision of the Douglas pouch peritoneum confirmed the presence of superficial endometriosis. The patient was scheduled for laparoscopic removal of the haemorrhagic cyst and excision of peritoneal endometriosis.

Results

We focus on the patient's left side: Initially, a superficial incision is made on the peritoneum, at the level of the ureter crossing the left common iliac vessels. Using blunt and sharp dissection, the ureter is mobilized carefully, with its vascular supply intact, and pushed laterally, off the posterior leaf of the broad ligament. The inferior hypogastric nerve is located two centimetres below and parallel to the ureter, in the meso-ureter, and 2 centimetres superior and parallel to the uterosacral ligament. To identify and preserve its fibres, following ureterolysis, the peritoneum is lifted at the level of the pelvic brim and dissection continued superficially and caudally, until the fibres of the inferior hypogastric nerve are visualized (**Figure 1**). In cases of peritonectomy for superficial peritoneal endometriosis, the nerve can be fully visualised and kept intact, by gently pushing its fibres off the affected peritoneum that will, subsequently, be excised. Having lateralized the inferior hypogastric nerve, blunt dissection is continued medially to the nerve, until the left uterosacral ligament is identified medially to it. Should the ligament also need to be excised, it can be done safely with minimal risk of injuring the nerve.

Conclusions

Preservation of the inferior hypogastric nerve is feasible and reproducible by following the surgical steps described here.

<https://player.vimeo.com/video/1085643273?autoplay=1>

Strategies for bleeding control in total laparoscopic hysterectomy

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Background

Predicting risk factors and managing them at the time of surgery is important for a safe procedure. In this presentation, we will present the factors leading to greater blood loss during total laparoscopic hysterectomy (TLH).

Methods

In 2024, we performed 190 TLHs for benign disease recording a mean blood loss volume of 115.49g. Among these cases, 11 patients recorded blood loss over 300g with five cases recording over 500g. We examined the operative records of these 11 cases to determine the risk factors that led to excessive blood loss and ways to prevent it.

Results

The average operative time was 74.3 minutes, and the average weight of the removed uterus was 273.64g. Of the 5 patients who recorded blood loss over 500g, four cases had a history of laparotomy. 4 cases suffered excessive bleeding due to poorly controlled bleeding around the uterine artery. 3 cases of excessive bleeding occurred at dissection of severe adhesion. One patient suffered excessive bleeding due to laceration of the pedicle at traction of a sub-serosal fibroid.

Conclusions

In TLH in cases which have undergone a previous laparotomy, special attention needs to be paid during dissection around the uterine artery and adhesion sites. By examining cases where greater blood loss occurs, we are better able to understand risk factors and develop management strategies for future surgeries.

<https://player.vimeo.com/video/1085557680?autoplay=1>

Challenges of Hysterectomy in an Endometrial Cancer Case Following Mesh-Based Ventral Hernia Repair

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Background

Laparoscopic hysterectomy in patients with previous mesh-based ventral hernia repair presents significant surgical challenges due to dense adhesions and altered abdominal wall anatomy. In endometrial cancer patients, however, complete surgical staging is essential. This video illustrates a technically demanding case of laparoscopic hysterectomy and staging in a patient with multiple prior abdominal operations, including mesh placement.

Methods

A 66-year-old woman with a history of multiple abdominal surgeries—including two ventral hernia repairs with mesh, appendectomy, urinary incontinence surgery, and breast mass excisions—was diagnosed with FIGO grade 2 endometrioid endometrial carcinoma. Her medical history included diabetes mellitus, hypertension, allergic asthma, and coronary artery disease.

The patient underwent laparoscopic total hysterectomy, bilateral salpingo-oophorectomy, and bilateral sentinel lymph node dissection under general anaesthesia. Pneumoperitoneum was established via Jain point due to anticipated adhesions. Upon laparoscopic entry, dense adhesions involving the anterior abdominal wall, bowel loops, and mesh site were encountered. Careful adhesiolysis was performed to access pelvic structures. During this process, a small serosal injury occurred on a bowel segment, which was promptly repaired with absorbable sutures.

Once adequate exposure was achieved, sentinel lymph node mapping was performed using indocyanine green. Near-infrared imaging enabled clear visualization and excision of bilateral sentinel lymph nodes. This was followed by bilateral salpingo-oophorectomy and total laparoscopic hysterectomy. The uterus, adnexa, and sentinel nodes were removed transvaginal. The vaginal cuff was sutured laparoscopically with absorbable material. Haemostasis was confirmed, and the operation was completed without further complication.

Results

The operation was completed laparoscopically in a patient with highly distorted pelvic anatomy. A serosal injury to the bowel occurred but was managed successfully intraoperatively. Sentinel lymph nodes were excised bilaterally; histopathology revealed one reactive node on the right and non-diagnostic adipose tissue on the left. Final pathology confirmed a FIGO grade 2 endometrioid endometrial carcinoma with <50% myometrial invasion and focal lymph vascular space invasion. No cervical or adnexal involvement was noted. The final stage was FIGO 2023 IA2. Immunohistochemistry revealed ER/PR positivity and mismatch repair deficiency due to loss of MLH1 and PMS2 expression, likely from epigenetic silencing.

Conclusions

This case demonstrates the feasibility of laparoscopic oncologic surgery in patients with complex surgical histories. Prior mesh repair significantly increases the technical difficulty of pelvic access and dissection. However, with careful adhesiolysis, modified entry techniques, and meticulous surgical planning, comprehensive staging procedures can be safely completed. This approach supports the use of minimally invasive surgery even in challenging gynaecologic oncology cases.

<https://player.vimeo.com/video/1085114123?autoplay=1>

Effectiveness of Curcuminoids in Controlling Postoperative Pain Following Total Laparoscopic Hysterectomy

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Background

A total hysterectomy is a common surgical operation in the field of gynecology, and the total laparoscopic hysterectomy (TLH) is particularly popular due to its advantages over open surgery. It offers better cosmetic outcomes, faster recovery times, and allows patients to resume their normal activities and work sooner. Despite these benefits, postoperative pain remains a notable concern, with studies showing that the occurrence of pain after TLH ranges between 35% and 63%. Current therapies for postsurgical pain, which are mainly opioids, have undesirable side effects, such as tolerance and dependence, and can eventually increase the chances of chronic postsurgical pain development. Curcumin has demonstrated a wide spectrum of therapeutic effects such as antioxidant, antidepressant, antispasmodic and of Gynecological effects. This study sought to assess the impact of adding curcumin to an enhanced recovery protocol on patients' recovery following TLH. This initial study was conducted to establish an adequately powered randomized controlled trial (a power of 95 % and a significance level of 0.01).

Methods

In this pilot trial, 40 participants were enrolled and randomly divided into experimental and control groups. Our clinical Enhanced Recovery After Surgery (ERAS) protocols were executed on patients. The experimental group began taking 100 mg of oral liposomal curcumin (administered as 50 mg twice daily) one day prior to surgery. Postoperatively, the administration of oral liposomal curcumin (50 mg twice daily) resumed 8 hours after surgery and continued for an additional two days. The primary objective was to evaluate the changes in postoperative pain levels, measured using the Visual Analog Scale (VAS), which ranges from 0 (indicating no pain) to 10 (indicating the worst imaginable pain) 24 hours after surgery.

Results

The patients showed no differences in baseline demographics or perioperative characteristics. The mean VAS at 24 hours post-surgery was notably lower in the study group compared to the control group (1.0 ± 0.4 vs. 1.8 ± 1.1 , $P = 0.007$). Despite the study group using less analgesia during the first 24 hours following surgery compared to the control group, this difference is not statistically significant, likely due to the limited sample size (1 [5.0%] vs. 4 [20%], $P = 0.34$). The total scores on the QoR-15 questionnaire were higher for those given curcumin (112.4 ± 2.2 vs. 105.6 ± 5.8 , $P < 0.001$).

Conclusions

Preliminary findings from our randomized controlled trial indicate that using curcumin as a treatment both before and after surgery in patients undergoing total laparoscopic hysterectomy is a safe and

effective approach. This strategy effectively alleviates postoperative pain, decreases the reliance on additional analgesics, and improves patient satisfaction. Our goal is to complete enrolment of 126 patients.

Hypogastric Vein Injury During Lumbosacral Nerve Decompression: A Rare but Critical Vascular Complication in Surgery for Sciatic Nerve Entrapment

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Background

Sciatic nerve entrapment syndrome may cause chronic pelvic pain and deep dyspareunia, especially in women, and is frequently misdiagnosed as a gynaecological disorder. Laparoscopic nerve decompression is an effective treatment option in selected patients unresponsive to conservative therapy. However, the complex pelvic vasculature poses a risk for intraoperative complications

Methods

A 42-year-old G2P2 female presented with chronic pelvic and groin pain aggravated by prolonged standing, alongside deep dyspareunia. Physical exam revealed hypertonicity and tenderness in the right obturator internus and a positive Tinel's sign at the right sacrospinous ligament. Pelvic MRI showed dilated vascular structures near the right sciatic nerve. Laparoscopic lumbosacral nerve decompression was planned.

Results

During retroperitoneal dissection, an iatrogenic injury occurred to the hypogastric vein, resulting in sudden and profuse venous bleeding. Haemorrhage was controlled with direct pressure, irrigation suction, and LigaSure vessel sealing. After achieving haemostasis, hematomas were evacuated, and the field was thoroughly irrigated. The patient recovered uneventfully and was discharged in stable condition

Conclusions

Lumbosacral nerve decompression offers an effective surgical option for patients with refractory pelvic pain. Nevertheless, complications such as hypogastric vein injury though rare can be critical. Surgeons must be proficient in pelvic vascular anatomy and prepared to manage intraoperative vascular emergencies to ensure optimal outcomes.

<https://player.vimeo.com/video/1085520940?autoplay=1>

Laparoscopic Cervical Cancer Surgery with Management of Duplicated Left Ureteral Tunnel without Uterine Manipulation

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Background

Patient Information: Ms. Chen, female, 42 years old, gravida 1, para 1. **Chief Complaint:** Postcoital bleeding for over 2 months.

Gynaecological Examination:

- Vulva: Normal development, no abnormalities observed.
- Vagina: Patent, with a small amount of dark red fluid noted.
- Cervix: Prominent columnar epithelium, blood crust formation observed post-biopsy, slight bleeding on contact, firm cervical texture, no abnormalities palpated in parametrial tissues or vaginal fornices.
- Uterus: Normal size, mobile, no tenderness, no palpable masses.
- Bilateral Adnexa: No abnormalities palpated, no tenderness.

Ancillary Examinations:

- HPV Testing: Positive for types 16, 33, and 44.
- Liquid-based Cytology (LCT): High-grade squamous intraepithelial lesion (HSIL).
- Colposcopy-directed Biopsy: Cervical invasive squamous cell carcinoma, invasion depth of 5 mm.
- MRI: Normal uterine size, thickened cervix with rich blood flow, no evidence of parametrial tissue invasion.
- Urinary System Colour Doppler Ultrasound: Left renal duplication anomaly.

Methods

Diagnosis: Patient diagnosed with stage IA2 cervical cancer, confirmed, with no fertility preservation requirements.

Treatment Plan: The preferred approach is laparoscopic radical hysterectomy with sentinel lymph node biopsy. The procedure adopts a non-uterine elevation technique and vaginal closure to ensure tumor-free principles. **Surgical Challenges:** The primary difficulty lies in the left duplicated ureter anomaly, which complicates ureteral tunnel dissection and introduces unpredictable factors. Caution is required during the isolation of the cardinal ligament vessels, as bleeding may increase the risk of ureteral injury.

Results

This surgical video demonstrates the anatomical principles of radical cervical cancer surgery, with a focus on tumor-free control. It addresses the significant challenge of managing a duplicated ureter anomaly to prevent injury. The critical aspect lies in the management of the ureteral branch of the uterine artery, which significantly reduces intraoperative bleeding and facilitates space dissection. Additionally, a stepwise approach to handling the cardinal ligament and the deep uterine vein minimizes bleeding, enabling smooth dissection of the ureteral tunnel and successful isolation and lateral displacement of the ureter.

Conclusions

The patient was ambulatory on the first postoperative day. Postoperative pathology revealed no metastasis in the sentinel lymph nodes. The cervical cancer lesion measured 1.8 cm × 1.5 cm, with infiltration into the inner third of the cervical stroma. Lymph vascular space invasion was negative. The urinary catheter was removed three weeks post-surgery. No adjuvant radiotherapy or chemotherapy was required, and the patient was advised to undergo close follow-up and regular check-ups.

<https://player.vimeo.com/video/1078893886?autoplay=1>

Ultrasound-guided myomectomy: A literature review and case series on robotic intraoperative ultrasound

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Background

Uterine fibroids (myomas) are the most prevalent benign uterine tumors, often leading to symptoms such as abnormal bleeding, pelvic pressure, pain, and reduced fertility. Myomectomy is the preferred surgical intervention to preserve fertility, especially in cases of multiple fibroids. However, detecting all fibroids intraoperatively remains challenging, particularly during minimally invasive procedures with limited tactile feedback. Intraoperative ultrasound (IOUS) has emerged as a valuable adjunct in various surgical disciplines. This narrative review and case series aim to evaluate the role of IOUS during myomectomy, specifically its ability to detect additional myomas and improve surgical outcomes.

Methods

A comprehensive literature review was conducted via the Medline database using a structured search strategy targeting studies involving IOUS during myomectomy. Inclusion criteria required the use of IOUS in gynaecologic surgeries involving fibroids, with exclusion of unrelated or non-intraoperative uses. Fourteen studies were identified. Additionally, a retrospective case series was compiled from ten patients who underwent robot-assisted myomectomy with laparoscopic IOUS at University Hospitals Leuven between January 2023 and December 2024. A drop-in ultrasound probe was used intraoperatively to identify additional fibroids, and postoperative imaging assessed surgical completeness.

Results

The literature review included studies involving transabdominal, transvaginal/transrectal, contact and laparoscopic ultrasound techniques. With IOUS, fibroid detection was significantly enhanced, with some studies also suggesting a decreased recurrence rate of symptomatic fibroids.

In our case series, IOUS using a drop-in probe during robot-assisted myomectomy enabled the detection and removal of additional myomas in 8 of 10 patients. Post-operative ultrasound imaging showed minimal residual fibroids (<2cm) in 5 of 10 patients. However, this does not indicate a failure of this surgical technique, as small fibroids without significant volume or impact on the cavity do not warrant additional incisions, thereby preserving the myometrial integrity.

Conclusions

IOUS enhances the detection of fibroids that might otherwise be overlooked during robotic-assisted myomectomy. This approach may reduce symptom recurrence and the need for reoperation, especially in complex polymyomatous cases. We present the first case series on the use of a drop-in probe during robot-assisted myomectomy. Although limited by its small size and retrospective nature, the current case series provides promising evidence that aligns with broader literature

findings. Future prospective studies with larger cohorts are warranted to validate IOUS as a standard adjunct in minimally invasive myomectomy procedures.

Lighting the way: Indocyanine green-guided laparoscopic transabdominal cerclage in pregnancy

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Background

Fertility-preserving treatments are becoming more common for patients with early-stage cervical cancer. However, resulting cervical insufficiency may increase the risk of preterm birth. When a vaginal cerclage is technically unfeasible or has repeatedly failed, a laparoscopic transabdominal cerclage (LAC) may be considered either preconceptionally or during early pregnancy. Laparoscopic surgery in pregnant patients poses significant challenges due to the enlarged uterus, which limits visualization and access to anatomical spaces, increasing the risk of injuries. Ureteral injuries occur in 0.2–1% of pelvic surgeries, typically at critical anatomical sites where the ureter is close to key surgical landmarks, such as the infundibulopelvic ligament, the anterior vaginal fornix, the ureteric tunnel, and the intravesical segment. Notably, approximately 70% of ureteral injuries are diagnosed postoperatively, highlighting the importance of intraoperative identification to enable timely repair and reduce morbidity. In this context, the use of indocyanine green (ICG) fluorescence could be an effective tool for real-time visualization of the ureteral course, helping to prevent iatrogenic or unrecognized injuries.

We herein report a case of post-conceptional laparoscopic cerclage, in which ICG fluorescence was utilized for the first time to guide the surgery, significantly enhancing ureteral visualization and consequently reducing the risk of intraoperative ureteral injuries.

Methods

A 37-year-old patient at thirteenth week of gestation with prior spontaneous abortion, two cone biopsies and a vaginal trachelectomy for cervical cancer relapse in 2022, was referred for cervical insufficiency. Due to the impossibility of a vaginal approach, laparoscopic transabdominal cerclage (LAC) was performed using a 3 mm polypropylene sling, as previously described. The procedure was carried out under indocyanine green (ICG) fluorescence guidance, with cystoscopic ureteral catheterization allowing real-time ureteral identification.

Results

No intraoperative blood loss or complications occurred. At 37 weeks, caesarean section was performed for foetal growth restriction, with normal maternal-foetal Doppler flow. The outcome was favourable (female newborn, 2510 g), with no need for cerclage removal.

Conclusions

ICG fluorescence guidance during LAC in pregnancy is safe and effective, providing constant visualization of the ureters and reducing the risk of injury. This technique improves surgical safety in complex scenarios, minimizing the need for postoperative ureteral stenting.

<https://player.vimeo.com/video/1085182095?autoplay=1>

Dyspareunia and sexual dysfunction after transvaginal specimen extraction - A systematic review

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Background

The aim of this study is to investigate the rate of postoperative dyspareunia and sexual dysfunction following transvaginal tissue extraction or NOTES procedures.

Methods

Through the databases EBSCOhost, MEDLINE, EMBASE, Cochrane, and PubMed a systematic review for eligible studies was performed. From there, the data quality was independently evaluated by three experts in the field. Included studies were originated from different specialties, therefore, it was subsequently divided into three subgroups: General Surgery, Urology, and Gynecology.

Results

A total of 1223 potentially relevant papers were identified, however, 379 studies did not meet our inclusion or exclusion criteria, 91 studies were excluded due to non-research articles, with no full text or unrelated to sexual dysfunction, 46 studies were also excluded due to: Duplication of cases, low anterior bowel resection cases, presence of endometriosis, history of total hysterectomy or adnexal surgery, and 71 studies were excluded due to single case report. In addition to this, seven studies were excluded due to being review articles. Consequently, 34 papers were included in the final review. After excluding the data of the patients with no postoperative sexual intercourse, and lost to follow-up, 2717 patients were included in the final review.

Conclusions

Vaginal tissue extraction or NOTES surgery can be performed with a low risk of sexual dysfunction or dyspareunia.

Dual minimal invasive approach for intravesical mid-urethral sling erosion: combining suprapubic and cystoscopic techniques

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Background

A 60-year-old patient presented to our clinic in October 2024 with complaints of urinary incontinence, recurrent urinary tract infection, and pelvic pain. The patient's medical history revealed previous surgeries, including two midurethral sling procedures performed approximately ten years ago, six months apart. The procedures were performed via transobturator and retropubic approaches, respectively. Pelvic ultrasonography revealed that the mesh had eroded into the bladder and extended into the bladder lumen. Considering the severity of the patient's current symptoms and the localization of the mesh, removal of the eroded mesh was planned via a transvesical approach through two trocars inserted from the suprapubic area under cystoscopic guidance. Following surgical removal of the mesh, the patient's pain resolved; however, urinary incontinence persisted. Considering the history of multiple prior surgeries for urinary incontinence, a periurethral bulking agent injection was attempted as a treatment. After the injection, the patient reported a noticeable improvement in urinary leakage.

Methods

While the bladder and the intravesical mesh were being visualized under cystoscopic guidance, the procedure was initiated by transvesically inserting two 3 mm trocars into the bladder, which had been distended with saline and elevated toward the suprapubic area. Following this, the mesh ends protruding into the bladder were identified, grasped, and freed using a grasper and scissors inserted through the trocars, and subsequently extracted transurethrally.

Results

The procedure was completed without complications. No recurrent erosion of the bladder mucosa by the mesh was observed within the 3-month follow-up period.

Conclusions

Using either the abdominal or transvaginal approach to excise eroded mesh requires subsequent closure of the bladder defect, causing more trauma to the patient. Consequently, we preferred a new, minimally invasive treatment for mesh erosion into the bladder.

<https://player.vimeo.com/video/1085798615?autoplay=1>

Lighting the Way: Intravesical ICG Fluorescence for Safer Bladder Dissection

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Background

Urinary tract injuries are a well-recognized risk during minimally invasive gynaecological surgery, with an overall incidence ranging from 0.3% to 0.8%. Bladder injuries are more common than ureteral injuries, with a reported incidence between 0.05% and 0.66%. Key risk factors include prior pelvic surgery, adhesions, distorted anatomy, gynaecologic malignancies, and surgeon inexperience. In recent years, Indocyanine Green (ICG) fluorescence imaging has emerged as a promising adjunct in gynaecologic surgery, especially for intraoperative identification of the ureters. ICG allows real-time, enhanced visualization under near-infrared (NIR) imaging and has shown to be particularly valuable in complex laparoscopic and robotic procedures involving distorted pelvic anatomy or patients at higher risk for urinary tract injury. While most studies have focused on intraureteral administration, the potential role of intravesical ICG instillation in improving bladder boundary recognition is still underexplored.

Methods

Stepwise video demonstration of intravesical ICG fluorescence imaging during laparoscopic pelvic surgery in a university hospital. Additionally, the show how this technique may assist in the intraoperative detection of small bladder injuries.

Results

We present a case involving a 72-year-old female patient diagnosed with POP-Q stage 3 pelvic organ prolapse, who was managed surgically with laparoscopic sacrocolpopexy and Burch Sacro colpopexy the procedure, 100 cc of an ICG solution diluted in saline (2.5 mg in 500 mL) was injected into the bladder. After 1 minute, near-infrared imaging was then performed, which enabled the clear visualization of the bladder dome and its limits, facilitating a safe and accurate dissection of the Vescio-uterine space. In the second case NIR imaging not only improved visualization of the bladder margins but also allowed early intraoperative identification of a small bladder lesion, which was immediately repaired.

Conclusions

Intravesical ICG fluorescence imaging represents a valuable intraoperative tool in gynaecologic pelvic surgery. It enhances bladder visualization during dissection, particularly in patients with risk factors for surgical difficulty. Furthermore, it supports the early detection of bladder injuries, potentially reducing postoperative morbidity. While the use of ICG is expanding in gynecology, its role in bladder visualization warrants further research to standardize protocols and assess clinical outcomes.

<https://player.vimeo.com/video/1085754368?autoplay=1>

The Introduction of the vNOTES Hysterectomy in the Netherlands: a nationwide cohort study

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Background

Vaginal Natural Orifice Transluminal Endoscopic Surgery (vNOTES) is a new technique for endoscopic surgery using the vagina as a natural entry to the abdominal cavity. Knowledge on the efficacy, safety, and the learning curve of the vNOTES hysterectomy is limited. Reported advantages are less postoperative pain and quicker recovery. This study aims to assess the peri- and postoperative outcomes of the vNOTES hysterectomy in the Netherlands during implementation.

Methods

Since the introduction of the vNOTES hysterectomy in the Netherlands in August 2019, gynaecologists trained in the technique have been asked to document their peri- and postoperative outcomes. This study collected the outcomes of 15 hospitals from August 2019 until September 2024.

Results

During this period 673 patients underwent a vNOTES hysterectomy. The mean operating time was 67 minutes (range 24-210). There were 37 (5.5%) conversions and 94 (15.5%) complications. Most conversions (26; 3.9%) were due to technical issues, eleven (1.6%) were due to perioperative complications. Patients with a body mass index (BMI) over 25 showed a significantly increased risk of conversion. Nineteen (2.8%) complications were perioperative, and 75 (12.7%) postoperative. Ten (1.5%) of the perioperative complications were classified as Clavien-Dindo (CD) 1, and nine (1.3%) as CD3. Postoperatively, 18 patients (3.1%) had a reintervention (N= 17 CD3, N=1 CD4), and two (0.3%) patients were admitted to the intensive care unit (CD4). The mean blood-loss was 127 mL (range 50-2000), and 220 (37%) of patients were discharged on the same day.

Conclusions

This large nationwide cohort study during implementation of the vNOTES hysterectomy demonstrates the safety and feasibility of this upcoming technique, reporting on a shorter surgery duration and a similar complication percentage compared to other methods of hysterectomy. The data reflects on the implementation of vNOTES in the Netherlands, and can be used as an overview of what to expect when a hospital implements this technique.

Ultrasound Checklist for a successful VNOTES procedure

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Background

We present a five-point sonographic checklist to be included as part of the preoperative evaluation prior to scheduling VNOTES surgery, aimed at identifying potential factors that may increase the risk of intraoperative complications.

Methods

Developed from both literature review and the authors' experience with 200 VNOTES cases, this ultrasound checklist aims to help surgeons—particularly beginners—identify factors that may increase intraoperative risk and select more manageable cases during the learning phase of the procedure. Additionally, we propose surgical tips and tricks that can be employed in uncertain scenarios to approach cases with greater safety and confidence.

Results

Five Key ultrasound Factors for Safe VNOTES:

Uterine Evaluation In early VNOTES cases, patients with uterine sizes up to 12 weeks of gestation (approximately 280 g) are preferred, as this size allows better visualization. Atrophic uteri, often found in postmenopausal women, may present technical difficulties, and should be approached cautiously. Uterine mobility is also critical; it should be evaluated and categorized as normal, reduced, or fixed (e.g., the “question mark sign”). Reduced or fixed mobility indicates possible adhesions and should be avoided initially.

Myoma Location The presence of low cervical, anterior, or isthmic myomas can significantly limit surgical access by reducing operative space. A minimum distance of 2.5 cm between the myoma and the cervix is advised to ensure easier and safer access.

Anterior Compartment Assessment Bladder injury is a major risk in VNOTES, particularly for patients with prior caesarean sections due to potential anterior adhesions. The anterior sliding sign, which shows free bladder movement over the uterine surface, can reliably indicate a non-obiterated vesicouterine space.

Posterior Compartment Assessment: A positive posterior sliding sign suggests a non-obiterated pouch of Douglas, associated with safe surgical access. Studies report over 90% accuracy in predicting favourable anatomy.

Adnexal Assessment Ovarian endometriomas, kissing ovaries, or fixed adnexa often indicate deep infiltrating endometriosis and severe pelvic adhesions. These features suggest complex surgery and are best avoided. Additional findings such as hydrosalpinx, hematosalpinx, or peritoneal cysts may signal prior pelvic infections or advanced disease and should be carefully reviewed.

Conclusions

The proposed checklist offers a structured approach to identifying anatomical or pathological conditions that may complicate VNOTES procedures. By relying on detailed transvaginal ultrasound assessment, surgeons- especially those in the early stages of experience- can better select appropriate cases and reduce intraoperative complications. With growing expertise, more complex cases can be considered.

A history of caesarean section increases the risk of bladder injury during anterior colpotomy. Techniques such as the “lateral window approach” or “anterior colpotomy under endoscopic visualization” have been shown to reduce this risk.

If transvaginal ultrasound examinations do not provide confidence in accessing the pouch of Douglas safely, a hybrid vNOTES approach—utilizing a 5-mm umbilical endoscope—can be employed to inspect the area prior to entry.

Vaginal hysterectomy versus vaginal Assisted NOTES Hysterectomy (VANH trial): results of a randomized controlled trial

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Background

Vaginal hysterectomy (VH) is widely regarded as the preferred approach for benign uterine pathology¹. However, the emergence of vaginal Natural Orifice Transluminal Endoscopic Surgery (vNOTES) offers an alternative that combines the advantages of endoscopic visualization with a scarless transvaginal route²⁻⁴. This abstract presents the results of the first randomized controlled trial (RCT) comparing VH with vaginal assisted NOTES hysterectomy (VANH).

Methods

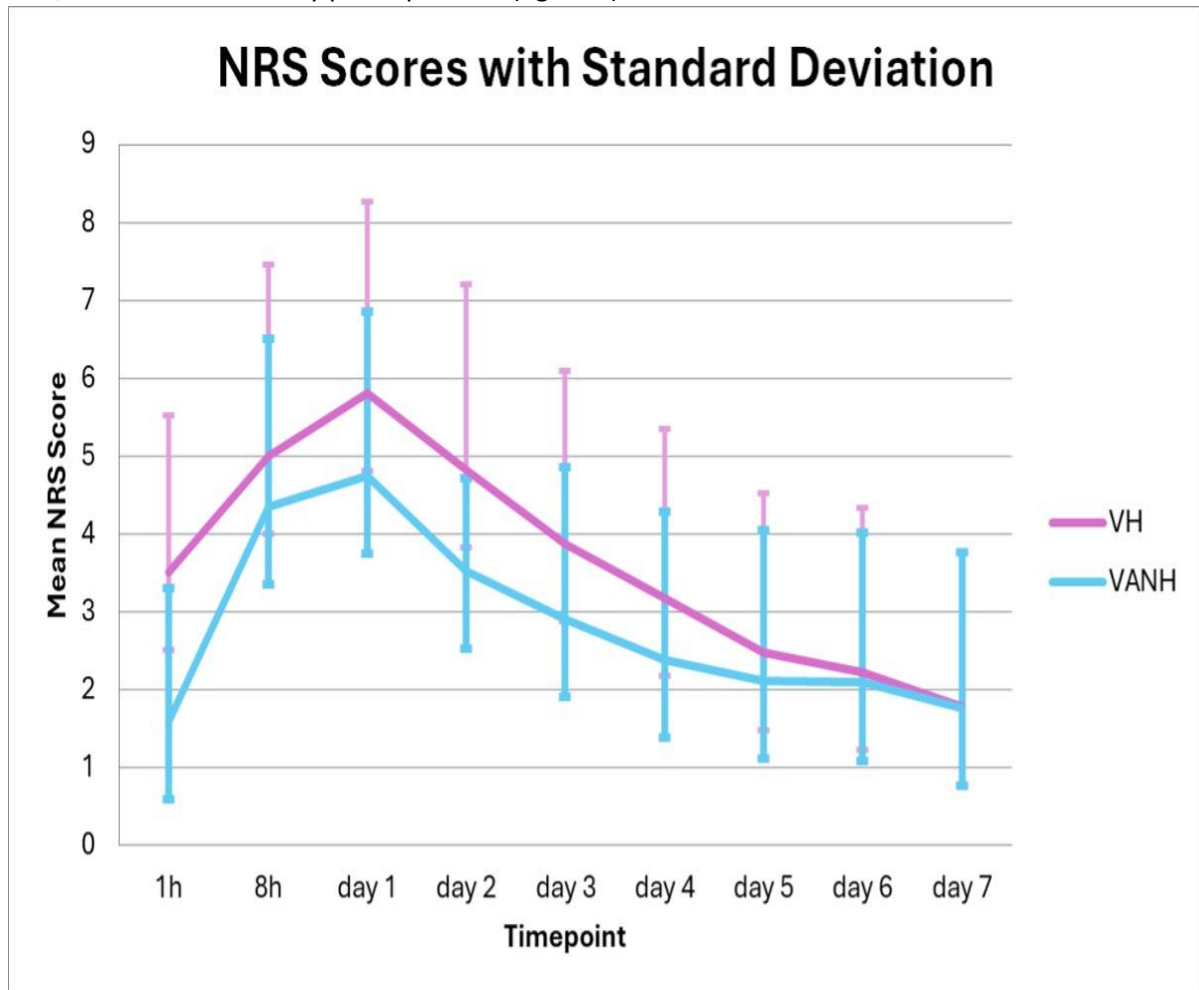
This multicentre RCT was performed in two non-academic teaching hospitals in The Netherlands. Eligible women requiring hysterectomy for benign indications were randomized in a 1:2 ratio to undergo either VH or VANH from July 2021 to February 2025⁵. Exclusion criteria are history of more than one caesarean section, endometriosis, rectal surgery or pelvic radiation, suspected rectovaginal endometriosis, history of pelvic inflammatory disease (PID), virginity, pregnancy, a contraindication for general anaesthesia or a contra-indication for same day discharge (SDD). Primary outcome was proportion of SDD. Secondary outcome measures were complications scored by Clavien Dindo classification, surgical outcomes (conversion rate, surgery time, blood loss, number of performed opportunistic salpingectomies per group), postoperative recovery (using the EuroQol 5- dimensions 5- levels questionnaire and Recovery Index- 10 (RI-10), pain first 7 days postoperative (Numerical Rating Scale (NRS)), quality of life and cost- effectiveness.

Results

A total of 106 patients were included (VH; n=38, VANH; n=68) with comparable baseline characteristics. SDD was significantly more often possible in the VANH group (88.2%) compared to the VH group (71.1%) (p-value 0.031, OR 3.06 (1.10-8.45)). Intention-to-treat analysis showed that VANH was associated with a shorter operative time (mean difference MD 9.61 min), less blood loss (MD 103.76 ml), more successful elective salpingectomy (OR 1.17, CI 0.61-2.26).

Conversion rate, intra- and postoperative complication rates, RI-10, and rate of re-admission were comparable between both groups. Pain scores significantly differed at 1 hour postoperative, the

first, second and third-day post-operative (figure 1).



Conclusions

The VANH trial demonstrates that patients undergoing VANH are more frequently eligible for SDD compared to those undergoing conventional VH. VANH offers several perioperative advantages over conventional VH, including shorter operative time, lower blood loss, and less operative pain. Furthermore, the transvaginal endoscopic approach allowed for more consistent visualization of the adnexa, resulting in a higher rate of successful concomitant elective salpingectomy. These findings support VANH as a safe and efficient alternative for VH, with an increased potential for outpatient management.

Literature Aarts et al. Surgical approach to hysterectomy for benign gynaecological disease.

Li et al. Transvaginal natural orifice transluminal endoscopic surgery (vNOTES) in gynaecologic surgeries: A systematic review.

Wasinghon et al. Transvaginal Natural Orifice Transluminal Endoscopic Surgery Myomectomy Followed by Hysterectomy.

Karkia, et al. Hysterectomy and Adenectomy via transvaginal natural orifice transluminal endoscopic surgery (vNOTES): A UK perspective with a case series of 33 patients.

Bekkers et al. VH versus VANH: a protocol for a randomised controlled trial.

Transvaginal natural orifice transluminal endoscopic surgery (vNOTES) for Sacrocolpopexy using Mersilene polyester suture

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Background

Sacrocolpopexy (SC) is commonly utilized for apical prolapse correction through laparoscopic, abdominal, or vNOTES (vaginal natural orifice transluminal endoscopic surgery) techniques, boasting low recurrence and high success rates between 83.1% and 100%. vNOTES has gained significant popularity in pelvic organ prolapse surgeries recently due to its rapid recovery, excellent patient satisfaction, and superior visualization. However, SC's use has become more restricted, largely because of the increasing number of FDA alerts about complications related to mesh. Research indicates that Mersilene tape presents a safer alternative to polypropylene mesh in sacrohysteropexy, providing similar effectiveness with reduced complication risks. This video article aims to present a minimally invasive, mesh-free solution for addressing pelvic organ prolapse (POP) using the vNOTES approach, incorporating hysterectomy, bilateral salpingo-oophorectomy, and SC with Mersilene polyester suture.

Methods

We assessed a 56-year-old woman with a previous history of two caesarean deliveries who came to our clinic experiencing pelvic pressure and the feeling of a vaginal bulge. She did not report any significant issues with bladder or bowel function. With a BMI of 36.4 kg/m², her weight is within the normal range. Both her personal and family medical histories noted no significant information. On physical examination, we found a stage III prolapse in both the anterior and central compartments, as well as a stage II prolapse in the posterior compartment. A pelvic ultrasound indicated that the uterus was of normal size without any abnormalities in the endometrium. Before the procedure, the patient gave written informed consent for the documentation and possible publication of the surgical video.

Results

The operation, taking 127 minutes, proceeded smoothly with an estimated blood loss of 110 ml. The patient was released the day after surgery, and subsequent follow-up appointments verified both anatomical success and the alleviation of prolapse symptoms.

Conclusions

vNOTES-SC using Mersilene polyester suture appears to be an effective option for addressing uterine prolapse. Additionally, it might serve as a viable alternative for treating apical defect POP Q stages III or IV.

<https://player.vimeo.com/video/1084848155?autoplay=1>

Fluorescent Endoluminal Coated Devices

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Background

After a brief review of fluorescence assisted surgeries we propose a new technique to increase safety during surgeries.

Bladder injuries during laparoscopic hysterectomy due to poor visualization or distorted anatomy because due to fibrosis from endometriosis, previous infections, previous surgeries like caesarean deliveries .

The bladder injuries could be reduced with proper visualization of the colpotomizer of the uterine manipulator.

So, we proposed a new technique to enhance his observation during surgeries using fluorescent techniques.

Methods

Minutes before the surgery the border of disposable uterine manipulator was painted with fine mixture of Indocyanine Green Dye and Surgical Glue and wait to be dried.

The uterine manipulator was inserted accordingly during the setup for the surgery.

During the procedure, as needed, the fluorescence overlay mode on laparoscopic camera was turned on, helping identify the boundaries of the colpotome of the uterine manipulator.

Results

The improved visualization of the colpotome helps during the surgery.

Conclusions

The use of a fluorescent coated colpotomizer could improve safety of that surgery.

It is a simple, fast, safe and low-cost way to coat an endoluminal instrument with Indocyanine Green Dye helping identify limits for the colpotomy despite the fog using monopolar hook.

That technique could be an applied in other endoluminal devices like circular staplers and probes.

<https://player.vimeo.com/video/1084604794?autoplay=1>

Laparoscopic cystectomy for a Collision tumour

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Background

Ovarian collision tumours, defined by the coexistence of two distinct histological types within the same ovary without cellular coalescence, pose diagnostic challenges and account for 0.26%, of gynaecological surgical cases. Common combinations include serous cystadenomas with mature teratomas and mucinous cystadenomas with endometriotic cysts. Concerns about the potential leakage of dermoid cyst contents, which leads to chemical peritonitis, raise hesitations regarding laparoscopic removal. This report presents a spill-free laparoscopic approach in a high-risk patient to manage such tumours effectively.

Methods

A case of a 37-year-old female with an incidental findings of left ovarian cyst during an evaluation for polycystic ovary syndrome (PCOS). The background history included a laparoscopic cystectomy for a dermoid cyst on the same ovary in 2018. A transvaginal ultrasound revealed a multiloculated left ovarian cyst with heterogeneous locules. Tumor marker CA 19-9 was noted to be elevated. An MRI of the pelvis confirmed a left ovarian neoplasm consistent with a mature cystic teratoma. After discussion in a gynecology multi-disciplinary meeting (MDT) meeting, agreed to proceed with a laparoscopic cystectomy using a spillage prevention protocol.

Abdominal access was achieved through Palmer's point. A suprapubic port was inserted into the cyst for decompression, resulting in the aspiration of clear fluid and fat. Dense adhesions between the omentum and the cyst were released. A 10 mm balloon port was then inflated within the cyst to facilitate its extraction without spillage. The cyst capsule completely excised extracorporeally and sent for histopathological analysis.

Results

Spillage free of cysts content.

Minimal blood loss.

Day case procedure.

Histological confirmation of co-existent benign mucinous cystadenoma and mature cystic teratoma.

Conclusions

Collision tumours are extremely rare in ovaries. This video illustrates the feasibility of laparoscopic spillage free cystectomy. Key strategies include direct cyst puncture, adhesiolysis and extra corporeal cystectomy.

<https://player.vimeo.com/video/1083354881?autoplay=1>

Vaginal Cuff Exparel—A Game Changer in Postoperative Pain Management?

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Background

To evaluate the effectiveness of adjunctive vaginal cuff infiltration with liposomal bupivacaine (Exparel) in improving postoperative pain control and recovery in patients undergoing robotic-assisted laparoscopic hysterectomy (RALH).

Methods

Retrospective cohort study.

Two academic tertiary care centres.

Women who underwent RALH for benign indications between January and November 2024.

Results

A total of 44 women were included, including 22 in each group. Age, body mass index (BMI), and parity was similar between groups. Mean uterine weight was comparable [436 g (IQR 330–634) vs. 390 g (IQR 213–860), $p=0.42$]. VAS scores prior to discharge were low and not significantly different between groups [2 (IQR 0–3) vs. 1 (IQR 0–2); $p=0.26$]. On postoperative day one, pain scores remained similar [4 (IQR 2–6) vs. 3 (IQR 2–6); $p=0.86$]. A non-significant trend toward reduced opioid consumption was observed in the study group ($p=0.07$).

Conclusions

Adjunctive vaginal cuff Exparel injection in addition to QL block may enhance postoperative pain management in RALH. Further prospective studies are needed to confirm these findings and explore the benefits of localized long-acting anaesthetic strategies.

Chromopertubation: Comparing Conventional Laparoscopy and Transvaginal Natural Orifice Transluminal Endoscopic Surgery – Which Approach Is Superior?

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Background

Tubal factor is responsible for approximately 30% of female infertility cases. Chromopertubation serves as a critical tool for its evaluation. The conventional laparoscopic (CL) technique is recognized as the gold standard for assessing tubal patency, as it enables direct visualization and examination of tubal and/or peritubal abnormalities. On the other hand, transvaginal natural orifice transluminal endoscopic surgery (vNOTES) is linked to reduced postoperative pain compared to CL, given its minimal tissue disruption and absence of abdominal incisions, making it a scarless surgical approach. This study was therefore designed to compare the accuracy of tubal patency assessment using Chromopertubation via CL versus vNOTES in infertile patients. To the best of our knowledge, no prior research has addressed this comparison.

Methods

A retrospective study was conducted on patients who underwent Chromopertubation between January 2020 and April 2025. Data on demographics, clinical characteristics, and postoperative pain scores were collected for individuals undergoing Chromopertubation through conventional laparoscopy and vNOTES.

Results

Chromopertubation was conducted on 32 patients using conventional laparoscopy (CL) and on 20 patients through vNOTES. The average ages in the CL and vNOTES groups were 33.0 ± 3.6 and 33.8 ± 1.8 years, respectively ($P=0.351$). No significant difference was noted in body mass index between the two groups (31.5 ± 5.7 vs. 30.7 ± 3.0 ; $P=0.568$). The mean parity was 0.6 ± 0.6 for the CL group and 0.8 ± 0.6 for the vNOTES group ($P=0.245$). At six hours postoperatively, pain scores were 4.0 ± 0.8 in the CL group and 3.9 ± 0.6 in the vNOTES group ($P=0.388$), with comparable results at 12 hours (2.0 ± 0.6 vs. 2.0 ± 0.9 ; $P=0.666$). Tubal assessment was achieved effortlessly in all cases across both groups. There were no recorded intraoperative or postoperative complications. The average postoperative hospital stay was 15.0 ± 4.3 hours for the CL group and 13.2 ± 5.3 hours for the vNOTES group ($P=0.174$).

Conclusions

Conventional laparoscopy and vNOTES Chromopertubation methods complement each other in terms of clinical safety, effectiveness, and patient preference. The decision between these techniques should be based on patient-specific factors and the expertise of the surgeon.

Treatment Strategies and Prognostic Indicators in Tubo-Ovarian Abscess: A Retrospective Study

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Background

To assess the clinical outcomes associated with various treatment approaches for tubo-ovarian abscess (TOA) and to identify key factors guiding the choice between conservative management, interventional radiology (IR)-guided drainage, and surgical intervention.

Methods

A retrospective study was conducted involving 92 patients diagnosed with TOA and admitted to New cross Hospital, UK, between January 2021 and April 2024. Comprehensive clinical data collected, including age, parity, intrauterine device (IUD) usage, presenting symptoms, laboratory parameters, and treatment modalities. All patients initially received intravenous antibiotic therapy. Subsequently, outcomes were analysed across three treatment groups: medical management, IR-guided drainage, and surgical intervention. Comparative analysis was performed to evaluate treatment efficacy, with statistical methods applied to identify significant differences and prognostic indicators among the groups.

Results

Among the 92 patients analysed, 29 (31.5%) were successfully managed with intravenous antibiotics alone, while 48 (52.2%) required surgical intervention, and 15 (16.3%) underwent IR drainage. Patients managed conservatively with antibiotics had a significantly lower mean age compared to those requiring intervention (36.2 vs. 46 years; $p = 0.04$). In contrast, the intervention group exhibited a significantly higher mean BMI ($p = 0.003$) and larger abscess sizes, with the majority presenting with abscesses exceeding 5 cm. Elevated C-reactive protein (CRP) levels were also notably more frequent in the intervention group ($p < 0.05$), suggesting a more severe inflammatory response. Despite these differences, the duration of hospital stays and the need for intravenous antibiotics did not significantly differ among the three groups.

Conclusions

Key predictors of poor response to conservative medical management included advanced age and abscess size exceeding 5 cm. IR-guided drainage emerged as a promising, minimally invasive alternative, particularly effective for larger abscesses in patients with elevated BMI. Nevertheless, the optimal management of TOA should be tailored to each patient, considering the clinical presentation, abscess dimensions, response to initial intravenous antibiotic therapy, and individual risk factors.

Deep Endometriosis: Bowel Resection With Trans anal Natural Orifice Specimen Extraction (Nose Technique)

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Background

We present the case of a 39-year-old woman who consulted for chronic pelvic pain characterized by severe dysmenorrhea (8/10), deep dyspareunia (10/10), dyschezia (8/10), and cyclic rectal bleeding. She also reported flatulence and symptoms suggestive of irritable bowel syndrome, along with primary infertility for over five years. Her history included two previous laparoscopic surgeries for endometriosis and medical treatment with dienogest, with no significant clinical improvement.

Methods

A transvaginal ultrasound following the IDEA protocol revealed deep endometriosis of the posterior compartment, including obliteration of the pouch of Douglas, involvement of the uterosacral ligaments and torus uterinus, and a 24x6 mm rectal nodule infiltrating the muscularis propria, located 12 cm from the anal verge. MRI confirmed these findings and showed additional retrocervical and peritoneal lesions, suggesting extensive deep infiltrating endometriosis.

Results

Given the extent and severity of the disease, surgical treatment was indicated. The patient underwent laparoscopic excision of deep endometriosis, segmental bowel resection with transanal natural orifice specimen extraction (NOSE), and end-to-side anastomosis.

Intraoperative findings confirmed the diagnoses. The dissection of the pararectal and rectovaginal spaces allowed segmental resection of approximately 4 cm of the rectum, and the excision of the uterosacral ligaments, torus uterinus, and posterior vaginal fornix.

Histopathological examination confirmed deep infiltrative endometriosis. The patient had an uneventful postoperative course and was discharged on postoperative day two with appropriate follow-up.

Conclusions

This case highlights the feasibility and benefits of minimally invasive bowel resection using the NOSE technique in the context of deep endometriosis, offering complete excision with reduced abdominal trauma and excellent short-term outcomes.

<https://player.vimeo.com/video/1090214039?autoplay=1>

Hysteroscopic and laparoscopic myomectomy during one operation

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Background

A 34-year-old patient complained of heavy menstruation during the last year. An MRI scan of the pelvis revealed a large-based type 0 myoma node located in the posterior wall, 4 cm in diameter; a type 2-5 myoma node located in the left lateral posterior wall; a type 4 myoma node located in the posterior right lateral wall, 20 mm in diameter; a type 4 13x11 mm myoma node located deep in the anterior wall and a type 6 myoma node measuring 22x13 mm in the anterior wall.

Methods

As a result of the examinations, the patient's haemoglobin value was found to be 7.6 g / dl. Against the background of intravenous iron preparations for 3 weeks, the haemoglobin value increased to 11,3 g / dl.

The patient then underwent a planned surgical procedure. The procedure consisted of diagnostic hysteroscopy, followed by surgical hysteroscopy using a Plasma Kinetic bipolar resectoscope, and then laparoscopic myomectomy. Hysteroscopic myomectomy was completed in 23 minutes with complete removal of type 0 myoma in 1 step, and 9 litres of saline solution were used.

To speed up the hysteroscopic procedure, at the beginning the fibroid is divided in the middle into two equal parts, after which they are also divided into smaller parts and removed from the uterine cavity

Results

After hysteroscopy, laparoscopic removal of 3 myomatous nodes was performed. Blood loss during the operation was about 200 ml. Haemoglobin after surgery was 10 g/dl.

Conclusions

Before performing a myomectomy, it is necessary to improve blood parameters to avoid blood transfusion during the operation. Simultaneous hysteroscopy and laparoscopy may be performed for different localizations of uterine fibroids. Dividing a large myoma node in half during hysteroscopy speeds up the procedure.

<https://player.vimeo.com/video/1092256980?autoplay=1>

Step-by-Step Temporary Clamping of Uterine Arteries and Utero-Ovarian Ligaments During Laparoscopic Myomectomy

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Background

Uterine leiomyomas are the most common benign tumors of the female genital tract and affect approximately 20–40% of women of reproductive age. Although frequently asymptomatic, they may lead to abnormal uterine bleeding, pelvic discomfort, or pressure symptoms depending on their size, number, and location. Surgical treatment of patients with large or multiple fibroids remains technically challenging and may be associated with increased intraoperative bleeding. Laparoscopic myomectomy, as a minimally invasive alternative, can be safely performed in selected cases with appropriate haemostatic techniques. Temporary vascular control methods, including bilateral clamping of the uterine arteries and utero-ovarian ligaments, may significantly reduce intraoperative blood loss and improve surgical visualization. In this video, we present a step-by-step demonstration of dual vascular control using temporary clamping of the uterine arteries and utero-ovarian ligaments during laparoscopic myomectomy for a large intramural fibroid.

Methods

A 23-year-old nulligravid woman presented with increased menstrual bleeding, fatigue, and pelvic pain persisting over the past three months. On physical examination, the uterus was palpated as consistent with a 16-week gestation. Transvaginal ultrasonography revealed a FIGO type 3 intramural fibroid measuring 8 cm in diameter. Laboratory tests showed a haemoglobin level of 9.6 g/dL and a haematocrit of 27.3%. Following a detailed consultation, laparoscopic myomectomy was planned.

Results

The procedure was successfully completed using a stepwise laparoscopic approach with temporary vascular clamping. Total operative time was 110 minutes, and estimated blood loss was 50 mL. No intraoperative or postoperative complications were observed. The patient was discharged on postoperative day 1 with an uneventful recovery.

Conclusions

Temporary vascular clamping of the uterine arteries and utero-ovarian ligaments during laparoscopic myomectomy is a safe and effective technique to reduce intraoperative bleeding and improve surgical visibility. This stepwise approach may simplify the management of large intramural fibroids and support faster recovery.

<https://player.vimeo.com/video/1090209040?autoplay=1>

Laparoscopic Myomectomy for Cervical Myomas. -Effective and Safe Surgical Strategies to Improve Fertility and Reduce Perinatal Complications-

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Background

Laparoscopic myomectomy (LM) for cervical myoma (CM) is more technically challenging than conventional LM due to factors such as displacement of the uterine artery and ureter, as well as impaired uterine mobility. To avoid complications such as massive bleeding, organ injury, and perinatal complications, surgical technique optimization is essential. In this presentation, we will present surgical videos of LM procedures for CM and analyse surgical outcomes in 58 cases.

Methods

We retrospectively reviewed 58 cases of CM treated with LM at our institution between 2006 and 2022, focusing on surgical outcomes and perioperative course. CM was classified into three types based on the extent of protrusion into the cervical canal: Intracervical type (IC), Extracervical type (EC), and intermediate type. In IC, where the tumor is confined to the cervical canal, the cervical canal is vertically incised, the nutrient vessels are ligated, and the tumor is enucleated. In cases where the tumor extends beyond the cervical canal (EC and intermediate type), temporary ligation of the uterine artery trunk is considered, followed by enucleation of the tumor after identifying the ureter. If part of the cervical canal is ruptured, the ruptured portion is repaired while a Hegar dilator is inserted into the uterine cavity.

Results

The median age (range) of 58 cases of CM was 36 (25–48) years, and 40 cases (69.0%) were nulliparous. The maximum myoma core diameter was 80 (30–140) mm, and 37 cases (63.8%) were single myoma. The site of onset was identified in 8 cases (13.8%) in the IC group, 31 cases (53.4%) in the EC group, and 19 cases (32.8%) in the intermediate type. Cervical rupture was observed in 74.1% (20/27 cases) of cases with intrauterine growth (IC and intermediate type) and in 19.4% (6/31 cases) of cases without intrauterine growth (EC). The surgical duration was 140 (48–297) minutes, intraoperative blood loss was 108 (5–600) mL, and uterine artery trunk clipping was performed in 6 cases (10.3%). Autologous blood recovery devices were used in 1 case (1.7%), but no blood transfusions were required, and there were no perioperative complications.

Among the 15 cases of infertility, 8 (53.3%) were conceived after surgery, and 5 (62.5%) of them were spontaneous pregnancies. There were no perinatal complications such as cervical incompetence or premature birth.

Conclusions

By establishing surgical strategies tailored to the location of CM onset, it is possible to complete LM safely.

Sculpting space: Navigating a giant cervical fibroid via minimally invasive Mastery

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Background

Heavy menstrual bleeding due to fibroids can complicate surgery, especially when cervical fibroids distort pelvic anatomy, displacing structures such as ureters and bladder. Laparoscopic hysterectomy in these cases requires careful dissection and a structured approach. This video presents a stepwise technique for laparoscopic hysterectomy with bilateral salpingo-oophorectomy (TLH-BSO) for a large cervical fibroid.

Methods

Case Presentation

A 47-year-old woman, Para 2, presented with heavy menstrual bleeding and multiple fibroids. MRI showed an enlarged uterus (10 × 9.7 × 11 cm) with multiple fibroids. The largest cervical fibroid measured 6 × 8 × 4 cm, arising near the internal os. The patient underwent elective TLH-BSO.

Results

Key Surgical Steps

Abdominal Entry: Pneumoperitoneum was achieved using Veress needle at sub umbilical point, insufflated to 20 mmHg. **Energy Sources:** Bipolar diathermy and harmonic scalpel were used for dissection and haemostasis. **Initial Uterine Mobilisation:** Round ligaments coagulated and transected bilaterally; anterior leaf of broad ligaments opened. **Ureterolysis:** Early bilateral ureterolysis to protect ureters displaced by fibroid. **Fibroid Mobilisation:** Cervical fibroid capsule opened; mass mobilised laterally and caudally. **Dissection Near Ureters:** Sharp dissection of fibroid from right ureter with care to avoid injury. **Uterine Artery Control:** Both arteries skeletonised; left clipped, right coagulated. **Bladder Dissection:** Uterovesical fold incised; bladder reflected sharply and bluntly. **Fibroid Enucleation & Colpotomy:** Fibroid enucleated; colpotomy performed at RUMI cup edge. **Vault Haemostasis & Closure:** Vaginal vault haemostasis with bipolar; closure with figure-of-eight and running sutures.

Conclusions

Laparoscopic hysterectomy is feasible and effective for large cervical fibroids. Early ureterolysis and systematic fibroid mobilisation are critical for safely managing complex anatomy and reducing complications in minimally invasive surgery.

<https://player.vimeo.com/video/1089953007?autoplay=1>

A multicenter, randomized, parallel-group, controlled trial comparing the efficacy of preoperative administration of relugolix with leuporelin in laparoscopic myomectomy (MyLacR study)

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Background

The oral gonadotropin-releasing hormone antagonist relugolix has been reported to be useful in improving uterine myoma-based symptoms and shrinking myomas. However, evidence of preoperative use of relugolix before laparoscopic myomectomy is limited. The aim of this study is to evaluate the non-inferiority of preoperative relugolix compared with leuporelin for the efficacy of reducing intraoperative blood loss in laparoscopic myomectomy.

Methods

This study was a multi-centre, randomized, open-label, parallel-group, noninferiority trial enrolling premenopausal women ≥ 20 years of age, diagnosed with uterine myoma and scheduled for laparoscopic myomectomy. Relugolix was taken as a 40-mg oral tablet once a day for 12 weeks, leuporelin was given as 1.88 mg or 3.75 mg subcutaneous injection three times at four-week intervals before the surgery. For the primary outcome measure of intraoperative blood loss, the number of patients required for analysis was calculated to be 64 (32/group) when the non-inferiority margin was set at 50 mL from the clinical perspective of laparoscopic myomectomy, with mean difference 0 mL, SD 70 mL, one-sided significance level 2.5%, and power 80%. Secondary outcome measures are other surgical outcomes (operative time, extracted myoma weight and number, blood transfusion, length of postoperative hospital stays), percent change of myoma size, bone density, postoperative menstrual recovery, and quality-of-life questionnaire responses (Kupperman Konenki Shogai Index and Uterine Fibroid Symptoms—Quality of Life).

Results

The full analysis set enrolled 32 patients in the relugolix group and 35 in the leuporelin group. Intraoperative blood loss (mean \pm SD) was 72.7 ± 74.4 mL (95% CI: 45.9, 99.5) in the relugolix group and 84.4 ± 87.5 mL (95% CI: 54.3, 114.4) in the leuporelin group, with an intergroup difference of -11.7 mL (95% CI: -51.5 , 28.1), $p = 0.0015$, validating the non-inferiority of relugolix to leuporelin. Other surgical outcomes, percent change of myoma size, menopausal-like symptoms, and disease-specific quality of life did not differ between the two groups, however, postoperative menstrual recovery and bone density recovery tended to be earlier in the relugolix group.

Conclusions

This study demonstrated that the non-inferiority of preoperative relugolix compared with leuporelin for the efficacy of reducing intraoperative blood loss in laparoscopic myomectomy.

Laparoscopic Intraligamentous Myomectomy with Round Ligament Reapproximation for Uterine Support: A Stepwise Surgical Approach

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Background

Intraligamentous leiomyomas, located between the folds of the broad ligament, represent a rare and surgically challenging variant of uterine fibroids. Their proximity to critical retroperitoneal structures, including the ureter and major vessels, necessitates a meticulous dissection strategy. Laparoscopic management offers superior visualization and faster recovery but demands advanced surgical skills. This video aims to present a structured and safe approach to laparoscopic intraligamentous myomectomy with concurrent uterine support reconstruction.

Methods

A 6 cm intraligamentous myoma was identified in a 36-year-old, nulliparous woman with chronic pelvic pressure. Following diagnostic laparoscopy, the right round ligament was selectively transected to expose the intraligamentous compartment. The myoma capsule was incised, and traction was applied using a laparoscopic tenaculum. Blunt and sharp dissection was performed with vessel-sealing devices (LigaSure) and (Harmonic), allowing enucleation while preserving adjacent structures. The excised specimen was retrieved via morcellation. The myoma bed was closed using interrupted and continuous laparoscopic sutures to restore uterine contour and secure hemostasis. To mitigate the risk of postoperative uterine prolapse due to ligament transection, the right round ligament was reattached to the uterus, and the left round ligament was strengthened by using delayed absorbable sutures.

Results

The procedure was completed without intraoperative complications. Total operative time and blood loss were within acceptable limits. Postoperative recovery was uneventful, and the patient was discharged within 24 hours. At 6-week follow-up, there were no signs of uterine descent or residual mass, and pelvic anatomy was preserved.

Conclusions

Laparoscopic intraligamentous myomectomy is a viable and effective approach when conducted with careful dissection and anatomical respect. Reapproximation of the round ligaments serves as a valuable adjunct to maintain uterine support. This video illustrates essential surgical principles, decision-making, and technical nuances, making it a valuable educational resource for advanced Gynecologic surgeons.

<https://player.vimeo.com/video/1085750894?autoplay=1>

Parasitic Leiomyoma

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Background

Uterine fibroids are the commonest benign Gynecological tumors. Parasitic leiomyoma is a rare variant of leiomyoma first described by Kelly and Cullen in 1909. The term parasitic is used to describe a lesion that has become attached to surrounding structures and has lost its attachment to the origin. The aim of this video is to show how to resect a parasitic leiomyoma which is located near bladder.

Methods

In this video, we present the case of a 46-year-old patient whose complaints of pelvic pain continuing after total laparoscopic hysterectomy.

Results

Before surgery, the patient underwent pelvic MRI and 6 cm lesion near the bladder has been showed. The procedure began with the placement of 10 mm main trocar via umbilicus and three accessories trocars on the anterior surface of abdomen. The retropubic area was opened by blunt and sharp dissections and the bladder was released. After that the mass on the right side of the bladder was removed. There were no intra- or post-operative complications. Histology of the mass was reported as leiomyoma.

Conclusions

Parasitic leiomyoma or leiomyomatosis peritonealis disseminata is an extremely rare variant of uterine leiomyoma occurring outside the uterus. According to the International Federation of Gynecology and Obstetrics classification parasitic leiomyoma has been classified as type 8. The most common symptom-if present, is abdominal pain, pressure, bloating during eating or nausea.

<https://player.vimeo.com/video/1085540578?autoplay=1>

Obstetrical Outcomes Following Laparoscopic Myomectomy: A Retrospective Study of 704 Cases at Strasbourg University Hospital (2004–2022)

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Background

Uterine fibroids are benign tumours characterised by proliferation of smooth muscle cells. In symptomatic patients, treatment is warranted. While hysterectomy has long been the standard approach, myomectomy may be offered when a pregnancy is desired. The main technical challenges of laparoscopic myomectomy lie in managing the risk of bleeding and ensuring a high-quality hysterotomy closure. Moreover, a history of myomectomy raises concerns regarding future obstetrical outcomes. Through this study, we sought to explore the impact of laparoscopic myomectomy on subsequent obstetrical outcomes.

Methods

This retrospective study was conducted within the Department of Gynaecology and Obstetrics at Strasbourg University Hospital, from 2004 to 2022. We analysed clinical and surgical characteristics, as well as details specific to the myomectomy procedure. Obstetrical outcomes following the surgery, along with patient satisfaction, were also assessed.

Results

Over the study period, 704 patients were included. Intrauterine cavity breach was reported in 82 cases (11.9%). A total of 198 patients (28.1%) underwent surgery in the context of a pregnancy wish. Among them, 71 subsequently became pregnant at least once, corresponding to a success rate of 46.71% in this indication.

Overall, 356 patients (57.5%) expressed a desire for pregnancy. Of these, 310 achieved at least one pregnancy (87.1%), and 211 (59.3%) had at least one live birth. We observed 78 spontaneous miscarriages, representing a rate of 25.2%.

Among the patients who had at least one live birth, 82 delivered vaginally, accounting for 38.9% of all live births. Fifty-nine patients (28.0%) underwent prophylactic caesarean section based on the surgeon's recommendation stated in the operative report, while 70 caesarean sections (33.2%) were performed for reasons unrelated to the surgeon's indication at the end of the myomectomy.

The mean gestational age at first delivery was 38.44 weeks of gestation.

We observed:

- 6 cases of threatened preterm labour (4.7%)
- 6 twin pregnancies (2.8%)
- 5 cases of premature rupture of membranes (2.4%)
- 2 cases of retroplacental haematoma (0.9%)
- 2 unexplained intrauterine fetal deaths (0.9%)
- 1 case of aseptic fibroid necrobiosis (0.5%)

- 1 case of placenta praevia (0.5%)
- 1 case of placenta accreta (0.5%)
- 1 case of pre-eclampsia (0.5%)

We recorded 13 cases of postpartum haemorrhage (6.2%), including 2 requiring blood transfusion (0.9%). Among the 211 pregnancies carried to term, one case of uterine rupture occurred outside labour, at 35 weeks of gestation, resulting in intrauterine fetal death.

Preoperative use of GnRH analogues, uterine artery embolisation, or temporary vascular occlusion showed no statistically significant impact on pregnancy rates

Conclusions

Laparoscopic myomectomy is a technique associated with low perioperative morbidity. It provides good functional outcomes; however, in the context of pregnancy, the rate of early spontaneous miscarriage is higher than in the general population, and the risk of uterine rupture must be acknowledged. These considerations should be openly discussed with patients during preoperative counselling.

Laparoscopic myomectomy and its perioperative complications: a retrospective observational study of 704 cases at Strasbourg University Hospital from December 2004 to December 2022

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Background

Uterine fibroids are common benign tumours that can cause menorrhagia, pelvic pressure, and pain. They may impair fertility and lead to miscarriage or preterm delivery. Management options vary according to symptoms and reproductive plans, and include medical treatments (progestogens, GnRH agonists/antagonists) and surgical approaches.

Myomectomy, particularly via laparoscopy, is the preferred option for women wishing to conceive. This study aims to evaluate the intra and post-operative complications of laparoscopic myomectomies performed at Strasbourg University Hospital between 2004 and 2022.

Methods

We conducted an 18-year retrospective study including all patients who underwent laparoscopic myomectomy at Strasbourg University Hospital. A total of 704 patient records were reviewed. The primary endpoints were intraoperative and postoperative complications.

Results

The mean age of patients was 37.7 years. The procedure led to an improvement in symptoms in 467 cases, representing 79.2% of the cohort. The average operative time was 121 minutes. Perioperative complications occurred in 3.69% of patients, including haemorrhagic events requiring transfusion (3.0%), laparoconversion (1%), and a single case of bowel injury (0.01%). Postoperative complications were observed in 3.55% of cases, with less than 1% readmission rate.

A significantly higher risk of endometrial cavity breach was observed in patients who received a GnRH analogue injection within the three months prior to surgery (10.9% vs. 17.7%, $p=0.05$). A significantly higher haemorrhagic risk was observed in the same groupe ($p = 0.02$).

In addition, patients who had undergone pre-operative uterine artery embolisation experienced more postoperative complications and required more blood transfusions ($p=0.02$). The use of temporary uterine artery occlusion was associated with longer operative times and an increased rate of cavity breach.

Conclusions

Laparoscopic myomectomy is a technique associated with low perioperative morbidity, which should nonetheless lead to clear and comprehensive patient counselling.

A Fertility-Preserving Management of a Large Recurrent Uterine Fibroid Using Hysteroscopic Resections and transcervical radiofrequency Myomablation mit SONATA

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Background

Managing large recurrent fibroids presents a significant therapeutic challenge for symptomatic patients seeking to preserve fertility. This case demonstrates a structured, multi-step strategy that integrates hysteroscopic resection, radiofrequency ablation, and medical therapy to progressively diminish fibroid volume while ensuring uterine integrity.

Methods

We present several cases of women with large uterine fibroids who underwent transcervical fibroid ablation using the SONATA system (an incisionless, ultrasound-guided radiofrequency ablation). Key procedural steps included intrauterine ultrasound mapping of fibroids, deployment of a radiofrequency probe into each fibroid, and thermal ablation in multiple overlapping zones as needed. Patient selection focused on those with symptomatic fibroids for which conventional surgery (e.g., hysterectomy or myomectomy) was high-risk or undesirable due to fibroid size, location, or fertility considerations. In one unique case, a 39-year-old with a 12 cm FIGO 0–1 fibroid underwent a staged approach: after medical pretreatment, an initial SONATA ablation combined with limited hysteroscopic resection was performed, followed by a second SONATA session months later to further ablate residual fibroid tissue. Conventional one-stage removal of a fibroid this size via hysteroscopic or open surgery would have been impractical, as such large myomas often require multiple surgical sessions for complete resection. This case highlights the niche for SONATA in managing fibroids deemed unsuitable for traditional approaches.

Results

Across these cases, SONATA achieved substantial fibroid reduction and symptom relief. The 12 cm fibroid case demonstrated a decrease in size to approximately 3–4 cm by final follow-up, with restoration of normal menstrual cycles and resolution of anaemia. Other patients with fibroids up to 8–10 cm (including those with multiple fibroids) also experienced significant symptom improvement, with minimal complications. On average, imaging at 12 months showed fibroid volume reductions on the order of ~60–70%, and 81–86% of women reported meaningful relief from heavy menstrual bleeding within the first few months. Notably, all patients avoided hysterectomy; uterine integrity was preserved in each case, aligning with fertility preservation goals.

Conclusions

Our experience indicates that SONATA offers a valuable, minimally invasive option for managing large fibroids in situations where conventional approaches would be challenging. Even fibroids measuring 10–12 cm, which would typically require multi-step resection or open surgery, can be treated effectively with transcervical radiofrequency ablation, sometimes in a staged or multi-session approach. This technology enables significant fibroid shrinkage and symptomatic improvement while avoiding abdominal incisions and excessive uterine trauma. In fertility-seeking patients, transcervical ablation preserves the uterus without the scarring associated with myomectomy, thereby

maintaining reproductive potential. SONATA thus expands the therapeutic arsenal for large myomas, bridging an important gap between hysteroscopic and more invasive surgical treatments.

From Septum to Conception: A Case of Deep Uterine and Complete Vaginal Septum Successfully Treated Prior to Pregnancy

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Background

To present the development of a spontaneous pregnancy following hysteroscopic resection and follow-up hysteroscopy in a patient with a deep uterine and complete vaginal septum.

Methods

A 28-year-old nulligravid woman with no history of systemic or Gynecologic disorders presented to our clinic with infertility, having failed to conceive despite three years of regular unprotected intercourse. Her menstrual cycles were reported to be regular, occurring every 30 days and lasting 4–5 days. Gynecological examination revealed a complete longitudinal vaginal septum and double cervix. Transvaginal 3D ultrasound was performed, which revealed findings consistent with a deep septate uterus. To confirm the diagnosis, contrast-enhanced pelvic MRI was ordered. MRI demonstrated a thin septum lined with myometrium dividing the uterus—including the cervix—into two separate compartments, favouring a diagnosis of septate uterus. A longitudinal band-like structure observed in the vagina was consistent with a vaginal septum. Both ovaries appeared normal on sonographic evaluation. Hysterosalpingography (HSG) was also performed, showing contrast passage between the two cavities at the isthmic level, which further supported the diagnosis of a broad-based septate uterus.

Surgical intervention began with the first hysteroscopy under ultrasound guidance, during which the vaginal septum was excised. Subsequently, both cervical canals were dilated, and operative hysteroscopy was performed. A deep uterine septum extending to the isthmus was observed within the uterine cavity. The septum was resected using scissors without energy-based modalities. Both tubal ostia were visualized and found to be normal. The cavity was considered adequately wide following the procedure. The operation lasted approximately one hour. Prior to discharge, the patient was prescribed a sequential estrogen–progestin regimen for one month and doxycycline for one week.

Results

Approximately one month after surgery, the patient underwent a second hysteroscopy during the follicular phase. The unified uterine cavity appeared single, regular, and of normal width. Both tubal ostia were clearly visualized. No adhesions or residual septum were observed. A minimal subseptal remnant was noted and resected in a limited fashion using scissors.

Two menstrual cycles after the follow-up hysteroscopy, the patient conceived spontaneously. At the time of reporting, the pregnancy is ongoing and progressing without complications.

Conclusions

This case represents a variant of complete uterovaginal septum, with a complete uterine and vaginal septum and partially communicating cervical canals, reflecting both resorption and incomplete fusion defects. This variant represents a rare form of Müllerian anomaly. In patients presenting with infertility, an accurate diagnosis requires thorough clinical evaluation, advanced imaging techniques, and endoscopic assessment. A combined surgical approach in a single session, followed by appropriate postoperative care and hormonal support, may yield favourable anatomical and reproductive outcomes. This case illustrates that meticulous planning and a multidisciplinary strategy can lead to spontaneous pregnancy in a relatively short time.

<https://player.vimeo.com/video/1085855096?autoplay=1>

Effectiveness of hysteroscopic subendometrial autologous PRP injection in women with advanced age, low ovarian reserve, and suboptimal endometrial thickness before FET using our guide

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Background

The purpose of this study is to assess the effectiveness of hysteroscopic subendometrial injection of autologous platelet-rich plasma (PRP) using our specialized guide. We aim to determine if this method can improve endometrial thickness in women of advanced age with diminished ovarian reserve and suboptimal endometrial thickness before frozen embryo transfer (FET).

Methods

A retrospective analysis was conducted on the results of 15 women whose embryo transfers had previously been cancelled due to suboptimal endometrial thickness (less than 7 mm). All patients received an injection of autologous PRP into the subendometrial zone during the luteal phase of the previous cycle of FET between cycle days 21 and 24. Subsequently, an artificial FET was performed in the following cycle.

Results

The average age of participants was 40.06 ± 3.75 years, and the average Anti-Müllerian Hormone (AMH) level was 0.61 ± 0.45 ng/mL. The mean pre-operative endometrial thickness was 6.18 ± 0.54 mm, while the post-operative thickness increased to 7.21 ± 0.53 mm. This indicates a significant increase in endometrial thickness following the hysteroscopic subendometrial injection of autologous PRP. Out of the 15 women who underwent artificial FET after the procedure, 5 became pregnant. Among these, 2 resulted in live births, while 3 ended in miscarriage.

Conclusions

Our method of subendometrial injection of autologous PRP enhances endometrial thickness, but its effect on the pregnancy rate remains uncertain.

<https://player.vimeo.com/video/1085438501?autoplay=1>

Hysteroscopic Resection of Type III Uterine Leiomyoma

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Background

This video illustrates a hysteroscopic electrosurgical protocol for complete resection of FIGO Type III uterine leiomyomas—intramural lesions adjacent to the endometrium—while prioritizing uterine integrity and fertility preservation. Key objectives include: (1) Demonstration of deep intramural fibroid resection without intracavitary protrusion; (2) Optimization of safety through controlled fluid management and adhesion prevention; (3) Validation of fertility outcomes via rapid postoperative conception.

Methods

A 29-year-old nulliparous patient with a 4.2 cm anterior intramural fibroid (overlying myometrium: 3 mm) underwent hysteroscopic resection under a structured protocol: (1) Preoperative Planning: Transvaginal ultrasound mapping of fibroid-endometrium spatial relationships. (2) Intraoperative Technique: Real-time sonographic guidance for targeted myometrial access; pseudo capsule-oriented resection under controlled distension pressure (≤ 80 mmHg); adjunctive oxytocin infusion to enhance uterine contractility. (3) Adhesion Prevention: Post-resection intrauterine instillation of hyaluronic acid gel.

Results

Complete fibroid excision confirmed by intraoperative ultrasound; restoration of myometrial thickness; fluid deficit 800 mL; same-day discharge. Second-look hysteroscopy at 2 months revealed preserved cavity architecture without adhesions; spontaneous conception occurred within 4 months post-procedure. No uterine perforation, transfusion, or readmission.

Conclusions

Hysteroscopic electrosurgical resection, augmented by intraoperative ultrasound guidance and adhesion prophylaxis, represents a fertility-sparing strategy for FIGO Type III fibroids. The protocol's efficacy—evidenced by anatomical restoration, rapid conception, and minimal complications—supports its application to select deep intramural lesions requiring precision resection. This video provides a reproducible model for optimizing fertility outcomes in Type III uterine leiomyomas management.

<https://player.vimeo.com/video/1079384399?autoplay=1>

Sharing Our Practice: Standardizing HyCoSy and Aqua Scans Through Structured Protocols and Training

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Background

To present our clinical experience with implementation of Hysterosalpingo-Contrast Sonography (HyCoSy) and Aqua Scans at Newham University Hospital.

Methods

A retrospective review was conducted of HyCoSy and Aqua Scan procedures performed between 2023 and 2024. All procedures followed a detailed Standard Operating Procedure (SOP), standardizing patient preparation, consent, antibiotic prophylaxis, analgesia, catheter insertion, contrast instillation, ultrasound imaging techniques, and post-procedure care.

The HyCoSy protocol involved transvaginal ultrasound assessment including ovarian reserve assessment using Antral Follicle Count (AFC), saline instillation for endometrial cavity evaluation (Aqua Scan phase), and Exem Foam contrast administration to assess fallopian tube patency under real-time imaging. In addition, 3D and 4D were used to enhance visualization of the uterine cavity and provide real-time assessment of tubal patency, improving diagnostic accuracy over standard 2D imaging. Outcomes assessed included procedural completion rates, patient satisfaction, complication rates, and patient pathway timelines.

Results

A total of 78 HyCoSy and Aqua Scan procedures were performed during the 2023–2024 study period by a trained gynaecologist. Among the patients, 51.65% were referred for primary subfertility and 27.35% for secondary subfertility. Patient feedback was overwhelmingly positive: 68.8% of patients rated their booking experience as 9 or 10 out of 10, 93.8% rated their HyCoSy procedure experience as 8 or higher, and 80% rated their overall satisfaction with the HyCoSy service as 10/10. Pain scores during the procedure were generally moderate, with most patients reporting pain between 3 and 7 out of 10. No major complications were reported. Post-procedure outcomes included ovulation induction in 30 patients, referral for IVF at Barts in 17 patients, private IVF referrals in 15 patients, weight loss advice given to 5 patients, and 8 patients lost to follow-up. The mean waiting time for HyCoSy was 75 days, and an average of 81 days from HyCoSy to outcome. Out of 78 patients, 7 (9%) are currently pregnant following spontaneous conception, 2(2.6%) had a live birth following spontaneous conception and 1 (1.4%) had a live birth following IVF. 3 (3.8%) are currently pregnant following ovulation induction, and 1(1.3%) achieved pregnancy through IVF. Four (5.12%) patients had ovulation induction but are not pregnant yet. Seven patients (9%) experienced a miscarriage.

Conclusions

We demonstrate the implementation of HyCoSy using a standardized SOP in a district general hospital setting. Compared to Hysterosalpingography (HSG), HyCoSy offers significant advantages as a radiation-free, real-time imaging modality that enables a comprehensive assessment of pelvic

anatomy, including evaluation of the uterus, endometrium, ovaries, blood flow, and ovarian reserve. Our results show that establishing a HyCoSy service is feasible in all secondary care centres, and given its clear benefits over HSG, it should be adopted as a standard diagnostic tool.

Pax8 Regulates Embryonic Female Reproductive Tract Stromal Development through Robo2

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Background

PAX8 is a master regulator of urogenital development, with recent exome sequencing of 442 MRKH patients revealing novel loss-of-function mutations in *PAX8* that disrupt Müllerian duct morphogenesis, further implicating its involvement in female reproductive tract development. Despite this genetic causality, the regulatory mechanisms driving *PAX8*-dependent reproductive tract formation remain unknown. This study employs murine models to dissect *Pax8*'s spatiotemporal control of epithelial-stromal crosstalk and downstream gene networks during ductal patterning, bridging the gap between human genetics and developmental mechanisms.

Methods

Pax8^{-/-} mice were generated via CRISPR/Cas9-mediated genome editing. Single-cell RNA sequencing (scRNA-seq) of embryonic day 13.5 mesonephric tissues was performed to delineate *Pax8*'s role in uterine morphogenesis and identify downstream regulatory networks. Chromatin occupancy of *Pax8* and its co-factors was assessed by Cleavage Under Targets and Tagmentation (CUT&Tag) assay. Key downstream regulatory networks were validated through multiplex immunofluorescence. To bridge murine findings to human pathology, endometrial RNA-seq was utilized to examine conserved transcriptional dysregulation in MRKH syndrome patients versus controls.

Results

Pax8^{-/-} female mice exhibited severe reproductive tract malformations characterized by the absence of key anatomical structures including a uterine cavity, continuous muscular layer, vaginal wall, and vaginal lumen. Single-cell RNA sequencing (scRNA-seq) identified 12 distinct cellular clusters—comprising Müllerian duct epithelium, uterine mesenchymal progenitors (UMDs), mesenchymal precursors (MPs), and coelomic epithelial precursors (CEPs)—with significant distributional differences across genotypes. The two clusters most enriched with knockout cells (KO-1 and KO-2) demonstrated greatest transcriptional similarity to UMDs, MPs and CEPs. *Robo2* expression was significantly upregulated in KO-1/KO-2 ($P < 0.001$). Immunofluorescence revealed substantially lower *Robo2* expression alongside higher *Pax8* levels in wild-type mesonephric tissue, compared with mesonephric tissue in *Pax8*^{-/-} female mice. CUT&Tag analysis confirmed direct *Pax8* binding to the *Robo2* promoter region. Clinically, dysregulated *ROBO2* expression was observed in MRKH syndrome patients.

Conclusions

PAX8 directs Müllerian duct development by specifying UMDs, MPs, and CEPs, while repressing *Robo2* to ensure normal development of female reproductive system. This first mechanistic elucidation of *PAX8* in reproductive tract development resolves a key gap in congenital malformation aetiology.

Surgical Management of Post-Caesarean Niche (Isthmocele) and uterine body polyp: A Minimally Invasive Approach

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Background

The worldwide incidence of a uterine niche following a Caesarean section (C-section) is variable, ranging from approximately 19% to 70%. C-section is highly prevalent in my region, and clinical cases of isthmocele are frequently encountered. Therefore, the minimally invasive surgical management of post-Caesarean niche requires, first, an accurate evaluation and, second, well-developed laparoscopic skills.

Methods

In this video we demonstrate step by step surgical management of post-caesarean niche (isthmocele) and uterine body polyp: A minimally invasive approach.

Results

We present a clinical case video demonstration of a 40-year-old female desiring future fertility.

Her chief complaints included abnormal uterine bleeding, pelvic pain, dyspareunia, and infertility.

Transvaginal ultrasound revealed the following findings: a uterine niche at the Caesarean section (CS) scar with a length of 26 mm, depth of 8 mm, residual myometrial thickness (RMT) of 1.6 mm, myometrial thickness near the niche of 2.4 mm, and an endometrial polyp measuring 8.9 × 4.8 mm.

After detecting the isthmocele via a laparoscopic approach, we introduced the hysteroscope into the uterine cavity under laparoscopic guidance. Using a bipolar resectoscope, the endometrial polyp was resected. With hysteroscopic guidance, we then identified and evaluated the post-Caesarean niche.

The next step is the resection of the isthmocele under hysteroscopic luminescence, while carefully avoiding injury to the urinary bladder. This is achieved by dissecting the bladder toward the pubic bone. For a successful operation, it is crucial to excise the isthmocele while ensuring healthy tissue margins.

The next step involves performing the first-layer closure using a continuous suture with Vicryl 2-0, under the guidance of a Hegar dilator.

The procedure concludes with the second-layer extracorporeal closure using intermittent PDS 1 suture.

Conclusions

At the 6-month follow-up, the myometrial thickness near the previously affected area measured 4 mm. Ultrasound confirmed that the post-Caesarean niche was no longer visible, and all patient symptoms had completely resolved. This video demonstrates a step-by-step approach to minimally

invasive niche resection. It serves as a valuable educational resource for surgeons aiming to improve their understanding and laparoscopic-hysteroscopic skills in managing post-Caesarean isthmocele

<https://player.vimeo.com/video/1085851907?autoplay=1>

Emergency laparoscopic cervical cerclage at 10 weeks' gestation in a patient with adverse obstetric history and prior fertility-sparing surgery for cervical cancer

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Background

Preterm birth (PTB) and second trimester loss (STL) is among the main causes of fetal morbidity and mortality, occurring in up to 9.6% of all deliveries. Cervical insufficiency, defined as the inability of the uterine cervix to retain a pregnancy in the absence of labour, is responsible for a great number of PTBs and STLs and can be present in 1% of all pregnancies. Therapeutic options include expectant management, progesterone supplementation, or surgical cerclage. A cerclage can be placed vaginally or abdominally (TAC). TAC is especially useful for women who have had previous cervical surgeries or for those who have a short or scarred cervix or in cases of failed prior transvaginal cerclage. Although TAC has traditionally been performed with an open approach, the laparoscopic (LPS) placement of cervical cerclage is spreading, due to many tangible advantages over laparotomy, such as decreased blood loss and pain, shorter hospital stay and faster recovery. On the other hand, when LPS-TAC is performed during pregnancies, surgeons are faced with several difficulties, including the inability to manipulate the uterus adequately, an increased risk of bleeding and the risk of pregnancy loss.

Methods

A narrated video-footage to illustrate the steps of a laparoscopic transabdominal cerclage technique

Results

A 33-year-old asymptomatic patient with previous history of fertility sparing surgery for IA1 cervical cancer and unfavourable obstetrical outcomes was referred to our centre with a sonographic diagnosis of cervical incompetence at 10 weeks of gestational age. Upon clinical examination, she was noted to have a short cervix with ballooning of the internal OS. At transvaginal ultrasound a shortened cervical length of 14 mm was observed. Following thorough counselling, a decision was made to proceed with laparoscopic cervical cerclage

Surgery was performed under general anaesthesia. Key surgical steps are indicated as follow: Identification of key anatomy; dissection of vesicouterine reflection; introduction of Mersilene tape; anterior-posterior needle pass under sonographic guidance; tying of a posterior knot. No intra-

operative or post-operative complications were reported. Overall operative time was 51 minutes. Postoperatively, the patient was admitted for clinical observation, fetal heart tone evaluation, and ultrasound for amniotic fluid levels. Antenatal care was provided by the Obstetrics Division. Patient was discharged on post-operative day 3.

She underwent an uneventful elective caesarean section at 35 weeks of gestation and the uterine incision was made above the tape leaving it intact.

Conclusions

LPS-TAC is a feasible and effective treatment for cervical insufficiency during pregnancy. It combines the inherent benefits of minimally invasive surgery with improved obstetric outcomes. Compared to laparotomy, LPS-TAC during pregnancy has demonstrated higher success rates and well-established advantages, including reduced blood loss, shorter hospital stays, less postoperative pain, and faster recovery. Importantly, the standardization of surgical techniques is essential to minimize the learning curve and ensure consistent results

<https://player.vimeo.com/video/1085852624?autoplay=1>

Management of Type I OHVIRA Syndrome presenting with hematometra and primary dysmenorrhea

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Background

Concerning the pathophysiology of mullerian duct anomalies, it is not common to see lateral and vertical fusion defects concurrently. OHVIRA syndrome is a rare mullerian anomaly of uterine didelphys with an oblique vaginal septum and ipsilateral renal agenesis. It is also called Herlyn-Werner-Wunderlich syndrome and the incidence is reported as 0.1% and %3 of all Mullerian anomalies. The patients may admit with pain or abnormal vaginal discharge. Treatment consists of minimal invasive surgery such as excision of the vaginal septum.

Methods

Here we present a 11-year-old girl admitting with severe dysmenorrhea that begins with menarche. In the history, it was learned that she had three cycles of menstruation which was lesser in amount and painful. Because she is virgin, bimanual examination was not performed. Pelvic ultrasonography revealed a bilobulated endometrioma like homogenous cystic mass in the right adnexal region. Laboratory tests were non-significant. For a definitive diagnosis magnetic resonance imaging (MRI) was decided. The report suggested uterine didelphys with associated hematometra. Ovaries were normal. Right kidney was absent. After the consent from the family has been taken, laparoscopy and hysteroscopy were decided due to unresolving pain and hematometra. While vaginoscopy, there was one vagina, a small cervical os and a small cavity on the left side. During simultaneous laparoscopy, uterine didelphys was seen with normal ovaries. Right sided uterus was larger than the left side due to hematometra. Also, the right salpinx was dilated with blood inside and adhered to the pelvic sidewall. Adhesiolysis was performed with slight traction of the tube. As the vagina was bulging from the left, oblique vaginal septum was seen. A diamond shaped excision was performed and blood was aspirated. Hysteroscopy showed a very dilated cervix in the right uterus. Hysteroscopic view of the right cavity with tubal ostium after blood aspiration was normal. Both tubal patencies were ensured. Vaginal incision was marsupialized with sutures and a very sufficient opening was observed. The hymen was intact (just stretched) after the operation. Postoperatively, she had no complaint of pelvic pain nor dysmenorrhea after the first cycle. Ultrasonography revealed uterine didelphys with similar regular cavities.

Results

OVHIRA syndrome is a very rare mullerian anomaly usually diagnosed around puberty. Obstructed hemivagina is a common sequela of this syndrome. In this case not only hematocolpos but also hematometra was seen and confused the diagnosis as a pelvic mass. MRI is the appropriate diagnostic procedure. The drainage of the uterus should be maintained by appropriate opening.

Conclusions

Both gynecologists and radiologists should be aware of this syndrome as the timing of diagnosis should not be delayed. Early recognition may prevent complications such as endometriosis and infections which may adversely affect fertility. Vaginal septum resection should be performed.

Effectiveness of tubal flushing with Lipiodol® in improving cumulative spontaneous pregnancy rates in patients with endometriosis: a case-control follow-up study

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Background

Lipiodol® is an oil-based contrast agent that has been shown to improve pregnancy and live birth rates in recent studies compared to water-based agents when used for tubal flushing. This study aims to assess the effectiveness of lipiodol in improving cumulative spontaneous pregnancy rates in women with endometriosis.

Methods

We conducted a case-control follow-up study involving endometriosis patients who underwent laparoscopic treatment and chromopertubation with or without lipiodol flushing at Cantonal Hospital of Schaffhausen between 2013 and 2023. Inclusion criteria were patients who actively attempted pregnancy postoperatively, with a minimum follow-up period of 6 months. Excluded were patients with bilateral tubal occlusion, patients without histological diagnosis of endometriosis and those whose partners had spermiogram with azoospermia. Propensity score matching (1:1) was performed for age, ASRM (American Society for Reproductive Medicine) classification, EFI (Endometriosis Fertility Index), tubal patency, uterine factors, and male infertility. The primary outcome was the cumulative spontaneous pregnancy rates postoperatively.

Results

A total of 118 women with and 103 women without Lipiodol® tubal flushing were included in the study. Both groups had comparable rates of primary infertility (64.4% vs. 70.9%, $p = 0.318$) and similar durations of infertility (25.0 ± 22.8 months vs. 27.8 ± 23.4 months, $p = 0.254$). The lipiodol group had higher spontaneous cumulative pregnancy rates at 3 and 6 months postoperatively [20.3% (24/118) vs. 6.8% (7/103), $p = 0.006$ and 29.7% (35/118) vs. 13.6% (14/103), $p = 0.005$, respectively], while the effect was comparable after 12 months of follow-up [37.2% (42/113) vs. 25/98 (25.5%), $p=0.132$]. Subgroup analysis according to EFI score revealed that women with an EFI score of 7-10 had a significantly higher cumulative spontaneous pregnancy rate at 3,6 and 12 months postoperatively after lipiodol tubal flushing, while women with EFI score less than 7 had comparable cumulative pregnancy rates regardless of lipiodol use.

Conclusions

Lipiodol tubal flushing increases cumulative spontaneous pregnancy rates at 3 and 6 months postoperatively, in women with endometriosis. The above benefit is more pronounced in patients with an EFI score above 7.

Case series of accessory cavitated uterine mass (ACUM): late appearance and reproductive outcome

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Background

Accessory cavitated uterine mass (ACUM) is described as a non-communicating, isolated, cavitated lesion into the myometrium close to the round ligament, with an otherwise normal uterine cavity. It is often misclassified as juvenile cystic adenomyosis, cystic adenomyoma, or non-communicating rudimentary horn. It often manifests with severe dysmenorrhea, chronic pelvic pain, and, rarely, dyspareunia or abnormal bleeding. Three cases of ACUM are presented discussing the delayed appearance and post-surgical reproductive outcome.

Methods

Case 1: A 28-year-old patient with normal menses presented with chronic severe dysmenorrhea. An isolated, cavitated cystic mass of ~4cm was found on the right side of the fundus close to the round ligament. Laparoscopic excision of the mass was performed. A small right ovarian endometrioma and peritoneal endometriosis were also found and treated. Nine years later, the patient was operated again for right ovarian endometrioma and extensive peritoneal endometriosis. Three years later, she conceived after IVF, and a healthy 3000 gr neonate was born vaginally.

Case 2: A 28-year-old patient wishing to conceive presented after 6 months of unsuccessful sexual intercourse. An isolated, cavitated uterine mass was discovered 6 months before on the left side of the uterine wall, close to the left round ligament. The mass was excised laparoscopically. The patient conceived naturally seven months later and born vaginally a healthy neonate of 3030 gr. Two years later, she was operated on for a benign right ovarian dermoid cyst. She is now again pregnant spontaneously.

Case 3: A 26-year-old patient presented with an anterior wall FIGO 3 fibroid of 5 cm underwent laparoscopic myomectomy. The post-operative follow-up three months later was normal. Nine months later, during her annual Gynecological examination, a left anterior isolated, cavitated, non-communicated uterine mass was found covering the myometrium close to the round ligament. The lesion was excised laparoscopically.

No complications were reported, and discharge was made the following day. Informed and written consent for presenting and publishing has been obtained from all patients.

Results

Symptoms resolved after surgery. Pathology reports and operative findings confirmed the diagnosis of ACUM. The patients experienced a normal evolution of their subsequent pregnancy, either natural conception, or after ART and delivered vaginally.

Conclusions

ACUM is considered an ectopic Mullerian tissue, currently under-recognized. Laparoscopic excision remains the gold standard. The late presentation years after menarche in all three cases might be explained by the possible late development of the mullerian remnant due to the potentially late expression of genes related to its formation. The late appearance during reproductive age needs to be further explored.

Chronic endometritis and reproduction: Correlation of pathology reports with endometrial culture results

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Background

Chronic endometritis has long been claimed as a risk factor for recurrent failures in reproductive treatments. Our aim was to find out compatible are pathology reports with endometrial culture results in cases with chronic endometritis?

Methods

This prospective cohort study was conducted at a private IVF centre between July 2020 and September 2022. Sixty patients undergoing hysteroscopy for various indications were triaged into three arms: patients with a history of implantation failure in IVF treatment constructed the first arm (#26), second arm included patients with a history of recurrent pregnancy loss (#19) and the third group confined patients undergoing H/S for other indications (#15). Endometrial sampling was performed in all cases prior to starting the H/S procedure.

Results

Demographic variables and percentage of history of healthy deliveries were similar for the three groups.

Number of pathological diagnosis and positive cultures are tabulated below:

	RIF	RPL	Other	p
No of patients	26	19	15	NA
History of healthy delivery	3	3	2	
+ Pathology	11 (42%)	10 (53%)	5 (33%)	
+ Culture	0	1	1	

RIF: Recurrent implantation failure

RPL: Recurrent pregnancy loss

Conclusions

Although sample sizes were relatively small, in our prospective study, we failed to reveal a difference in incidence of CE when RIF cases were compared with RPL cases and other indications. Chronic endometritis seems to be just coincidental finding in implantation failure cases and its incidence is no different than that of the population undergoing HS for other indications.

A Prospective Study on the Efficacy and Safety of Non-Surgical Management for Intrauterine Retained Products of Conception

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Background

To investigate the safety and efficacy of non-surgical management for intrauterine retained products of conception (RPOC).

Methods

The clinical data of patients who underwent non-surgical management for intrauterine RPOC were prospectively collected from the Department of Gynecology at Third Xiangya Hospital of Central South University between January 2023 and December 2024. Additionally, analyses were conducted on spontaneous expulsion or conversion to surgical treatment during follow-up, along with the incidence of complications including major hemorrhage and infection. This study was approved by the institutional review board of the Third Xiangya Hospital of Central South University (IRB no. I 22282).

Results

This prospective cohort study enrolled 278 patients with intrauterine RPOC, demonstrating the following outcomes: spontaneous expulsion occurred in 184 cases (66.19%), 69 patients (24.82%) underwent surgical conversion (64 by personal preference and 5 due to haemorrhagic complications), with 25 cases (8.99%) remaining under surveillance. Temporal analysis revealed expulsion/surgical rates across follow-up intervals: 0-30d [4 (2.17%, 4/184) vs 5 (7.25%, 5/69)], 31-60d [43 (23.37%, 43/184) vs 14 (20.29%, 14/69)], 61-90d [60 (32.61%, 60/184) vs 26 (37.68%, 26/69)], 91-120d [46 (25.00%, 46/184) vs 12 (17.39%, 12/69)], and >120d [31 (16.85%, 31/184) vs 12 (17.39%, 12/69)]. Major hemorrhage occurred in 8 cases (2.88%, 8/278), all emergently controlled with pharmacotherapy - 5 proceeding to surgery and 3 resolving spontaneously with non-surgical management. No cases necessitated uterine artery embolization or hysterectomy. Transient C-reactive protein elevation was observed in 4 patients (1.44%, 4/278), none of whom developed clinically evident infection.

Conclusions

Non-surgical management for intrauterine RPOC is safe and effective without major bleeding or infection, supporting its role as a primary conservative option. Its endometrial protection and fertility benefits warrant further investigation.

Robotic Removal of Vaginally Eroded Sacrocolpopexy Mesh Following Recurrent Prolapse: A Stepwise Surgical Video

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Background

While sacrocolpopexy is the gold-standard treatment for apical prolapse, mesh-related complications such as erosion, pain, or infection may necessitate surgical removal. Complete robotic mesh explantation is rarely performed and underreported in the literature. This video demonstrates a technically demanding case of robotic mesh removal performed for vaginal mesh erosion and recurrent posterior compartment prolapse, highlighting its feasibility, safety, and surgical teaching value.

Methods

A 67-year-old woman with a history of total laparoscopic hysterectomy (TLH) and bilateral salpingo-oophorectomy (BSO) followed by sacrocolpopexy in 2019, and reoperation in 2020 for prolapse recurrence, presented to the urology department with dysuria, pelvic pain, and abnormal discharge. She was subsequently referred to gynecology for further evaluation. Examination revealed a 2 cm mesh erosion at the vaginal cuff and stage 4 posterior compartment prolapse (POP-Q: C: 2, Ap: 0, Bp: 3, Aa: 0, Ba: -2).

Robotic exploration was performed using the da Vinci Xi system under general anaesthesia. Following port placement and lysis of adhesions, the mesh was identified along the retroperitoneal tract from the sacral promontory to the vaginal apex. Using sharp and blunt dissection with bipolar cautery, the mesh was mobilized and detached from both its sacral fixation point and the vaginal cuff. The cuff defect was closed with 2-0 barbed suture. Peritoneal closure was performed over the dissected area.

The procedure was completed with a posterior colporrhaphy via perineal approach, including excision of redundant vaginal mucosa and levator ani muscle plication. Total operative time was 95 minutes.

Results

The procedure was completed uneventfully with no intraoperative or early postoperative complications. Histopathology confirmed foreign body-type giant cell reaction and chronic inflammation, consistent with mesh-related fibrosis. At follow-up, the patient reported resolution of pelvic pain and urinary symptoms, with no recurrence of prolapse and marked improvement in quality of life.

Conclusions

Robotic mesh removal is a feasible and safe approach in patients with mesh erosion and recurrent prolapse, even after multiple prior pelvic surgeries. Robotic assistance provides enhanced visualization and precise dissection of deeply embedded mesh, facilitating complete removal while minimizing complications.

<https://player.vimeo.com/video/1090092614?autoplay=1>

Resurgence of Vaginal Surgery in the Age of Endoscopic Innovations: Preliminary Total Vaginal-NOTES Results from 14 Cases

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Background

Jan Baekelandt identifies two primary techniques for vaginal NOTES hysterectomy. The first, Vaginally Assisted NOTES Hysterectomy (VANH), begins with vaginal dissection of the lower uterus under direct visualization, followed by transvaginal endoscopic completion. The second, Total Vaginal NOTES Hysterectomy (TVNH), conducts the entire uterine dissection exclusively via transvaginal endoscopy, using only a camera and specialized tools. While VANH often encounters challenges during transvaginal colpotomy, TVNH benefits from improved visibility through endoscopic techniques and CO2 pressure, facilitating tissue separation and seamless execution of both anterior and posterior colpotomies. This proves particularly advantageous for patients without previous vaginal deliveries or with caesarean histories. This article highlights my initial experience with TVNH, evaluating its feasibility, safety, perioperative outcomes, and patient satisfaction.

Methods

This observational retrospective study was carried out from 2024 to 2025 in the Department of Obstetrics and Gynecology at Mugla Sıtkı Kocman University Medical Faculty Training and Research Hospital. The data were collected retrospectively from the hospital's electronic medical records system, encompassing preoperative, intraoperative, and postoperative information for all participants. All vNOTES procedures were performed utilizing Alexis and Vpath Gel paths (Video).

Results

Throughout the study period, 14 patients underwent total vaginal NOTES hysterectomy in combination with either bilateral salpingo-oophorectomy or salpingectomy. Among these individuals, 4 patients (28.6%) had a previous history of one caesarean section, 6 patients (42.9%) had undergone two or more caesarean deliveries, and 4 patients were nulliparous. The surgical procedures were performed for indications such as high-grade squamous intraepithelial lesions or in situ cervical carcinoma (42.9%), endometrial hyperplasia or malignancy (35.7%), and adnexal masses (21.4%). The mean operative time was 76.0 minutes with a standard deviation of 19.2 minutes. On average, haemoglobin levels dropped by 1.1 g/dL (± 0.6). Postoperative pain, as evaluated using the visual analogue scale, showed mean scores of 5.4 (± 1.2) at 6 hours and 1.6 (± 0.7) at 24 hours after surgery. The average hospital stays lasted 19 hours (standard deviation: 2.8). The calculated mean uterine weight was 107 grams (± 36). Importantly, no perioperative or postoperative complications were reported.

Conclusions

TVNH for benign uteri was performed successfully and safely in well-selected parous and nulliparous patients. The presence of pneumovagina means that TVNH is no more challenging in nulliparous

women than in parous ones. In contrast, restricted vaginal access may increase the difficulty of performing a traditional vaginal hysterectomy. However, the study has certain limitations, such as a relatively small sample size and the absence of comparative evaluation.

<https://player.vimeo.com/video/1088102990?autoplay=1>

Minimally Invasive Ventral Rectopexy for Vaginal Enterocoele: A Multicenter Study on Anatomical and Functional Results

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Background

Posterior compartment prolapse is a form of pelvic organ prolapse (POP) that affects a significant number of women worldwide, particularly those who are elderly. Anatomically, the posterior compartment prolapse can manifest in various forms, each with its own set of clinical implications. The most common manifestations of posterior compartment prolapse include rectocele, enterocele, and rectal prolapse. The primary aim of this study is to assess the anatomical and functional outcomes of minimally invasive ventral rectopexy (VRP) in patients diagnosed with enterocele. VRP is a procedure that has been increasingly utilized to restore anatomical support and correct rectal prolapse, as well as improve functional outcomes for patients with multicompartamental prolapse. In cases of enterocele, VRP can be particularly effective, with some evidence in the literature supporting its efficacy in these conditions.

Methods

We present a retrospective multicentric study conducted between February 2021 and February 2025 at the gynecology department of Jeanne de Flandre Hospital, Lille, France and at the Fondazione Policlinico Universitario Agostino Gemelli–IRCCS, Rome, Italy. Women affected by symptomatic enterocele who underwent minimally invasive VRP were included in the study. All women with symptomatic vaginal enterocele with or without anorectal symptoms and treated by minimally invasive VRP were retrospectively included. Primary outcome was to evaluate anatomical posterior compartment outcomes at more than 6-month follow-up. Secondary outcome was to describe functional outcomes, peri- and postoperative complications. Pearson chi-square test, McNemar test, and exact Fisher test were adopted for categorical variables, while t-test, intergroup Mann-Whitney U test and intragroup Wilcoxon Rank Sum Test for continuous variables; the statistical analysis was conducted at 95 % confidence level.

Results

Seventy women were included. Rectal prolapse (RP) was present in 31.4% (22/70) of the study population. Additional surgeries at time of VRP was anterior sacrocolpopexy (SCP) in 65.7% of women (46/70). At more 18-month follow-up, anatomical posterior compartment relapse was 1.4%

(1/70). Considering functional outcomes, constipation and incontinence Wexner score significantly improved in the study population. Most of anorectal symptoms significantly improved at follow-up. There was no reintervention for prolapse relapse. No difference in anatomical and functional outcomes was highlighted between women who presented or not a RP. Considering post- and peri-operative complication, 1 woman (1.5%) required the resection of the mesh for infection of the implanted material.

Conclusions

This study demonstrates that VRP is an effective and safe treatment for vaginal enterocele, providing significant anatomical and functional improvements with a low complication rate.

Laparoscopic vs robotic ventral rectopexy for posterior compartment disorders: a multicentric study in a Gynecological setting

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Background

Primary aim of this study is to assess anatomical and functional outcomes of minimally invasive ventral rectopexy (VRP) in patients with posterior compartment defect, comparing the laparoscopic (L-VRP) and the robotically assisted (R-VRP) surgical route.

Methods

a retrospective multicentric study conducted between February 2021 and February 2025 at the gynecology department of Jeanne de Flandre Hospital, Lille, France and at the Fondazione Policlinico Universitario Agostino Gemelli–IRCCS, Rome, Italy. Women with posterior compartment defect who underwent minimally invasive VRP were retrospectively included. Posterior pelvic floor disorders considered eligible for VRP were symptomatic enterocele or rectal prolapse (RP). Primary outcome was to evaluate anatomical posterior compartment outcomes at more than 6-month follow-up, comparing L-VRP and R-VRP. Secondary outcome was to describe pelvic functional outcomes, peri- and postoperative complications according to the surgical route, and predictive factors for posterior compartment recurrence, postoperative constipation and anal incontinence (AI).

Results

102 women were included, 60 in the L-VRP group and 42 in the R-VRP group. Preoperative analysis showed that 68.6% (70/102) of women presented an enterocele, while 39.2% (40/102) had an associated rectocele. Moreover, 37.3% (38/102) of patients had a significant RP (defined as ≥ 3 stage according to the Oxford Prolapse Grading System). Additional surgeries at time of VRP was anterior sacrocolpopexy (SCP) in 70.6% (72/102), and subtotal hysterectomy in 51.0% (52/102) of women. One patient (1%; 1/102) had to interrupt the surgical procedure in consideration of the abdominal and pelvic adhesions. At a mean of 18-month follow-up, overall anatomical posterior compartment relapse was 1.0% (1/101), without difference between groups. Almost all anorectal symptoms improved in the general population and in subgroups. No difference in prevalence of anorectal symptoms between subgroups was reported at follow-up. The constipation and incontinence Wexner score significantly improved postoperatively in the study population, without differences between subgroups. Postoperative anterior and central compartment results did not significantly differ

between groups. Considering peri- and post-operative complications, 1 woman (1.0%; 1/102) required a resection of the mesh for infection of the implanted material in the L-VRP group (1.7% vs 0%). There was 1 reintervention for POP recurrence in the R-VRP group (0% vs 2.4%). Preoperative constipation and preoperative AI emerged as risk factors for postoperative constipation. Preoperative AI emerged as risk factor for postoperative AI, whereas preoperative constipation appeared to be inversely associated with postoperative AI.

Conclusions

This study demonstrates that minimally invasive VRP is an effective and safe treatment for posterior compartment defects, providing significant anatomical and functional improvements with a low complication rate. No difference in anatomical and functional outcomes emerged according to the surgical route.

Robotic Resection of a Vaginally Exposed Mesh:

A Rare Complication of the Lateral Suspension for pelvic prolapse

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Background

The lateral suspension technique for managing female pelvic prolapse is considered a safe procedure, performed away from critical structures such as blood vessels, ureters, and intestines.

Methods

This case is about a 50-year-old woman (G3P2) who, after five years of pelvic prolapse management, developed vaginal mesh exposure in the fornix, associated with recurrent vaginal infections and chronic pelvic pain.

Clinical examination showed a 3x2 cm exposed mesh on the anterior fornix.

An MRI revealed that the infection had progressively extended to both arms.

Given the severity and rarity of the case, the management posed significant challenges.

A laparoscopic robotic-assisted resection of the mesh was considered the optimal option.

This minimally invasive procedure aimed to address the infection and prevent further complications, ensuring the best possible outcome for the patient.

After a discussion of the procedure and its risks, the patient consent to proceed with the surgery.

Results

The postoperative course was uneventful. The control at four weeks showed a good clinical and anatomical recover, with no recurrency of vaginal prolapse and resolution of the biological inflammatory syndrome.

Conclusions

The management of a vaginally exposed mesh is a challenging situation. In this case, the rarity and severity of the presentation contributed to the complexity of the management. Robotic-assisted laparoscopic mesh resection proved to be a safe and effective approach, enabling precise removal of the infected material while preserving surrounding structures and reducing postoperative morbidity.

<https://player.vimeo.com/video/1085747134?autoplay=1>

Total Retroperitoneal Uterosacropexy via vNOTES A Minimally Invasive Approach for Apical Prolapse Repair

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Background

The presented video demonstrates a newly developed technique for total retroperitoneal uterosacropexy performed via the vaginal Natural Orifice Transluminal Endoscopic Surgery (vNOTES) approach. This method represents an adaptation of the retroperitoneal dissection technique initially introduced by Baekelandt and Stuart in combination with a Manchester-Fothergill repair (Baekelandt and Stuart, 2023). Our modification limits the extent of dissection while preserving the benefit of precise, anatomically aligned apical suspension.

Compared to conventional laparoscopic sacropexy, the vNOTES approach offers reduced postoperative pain, avoidance of abdominal incisions, and may shorten hospital stay. It is particularly suitable for patients with previous abdominal surgery or adhesions and allows combination with anterior/posterior colporrhaphy or hysterectomy.

Methods

The procedure utilizes a retroperitoneal access route via posterior colpotomy without entering the peritoneal cavity. Under endoscopic visualization, the anterior longitudinal ligament is exposed, and a permanent suture is placed for uterine or vaginal apex suspension. Key anatomical structures such as the rectum, hypogastric nerves, and ligamentous landmarks are clearly visualized and preserved. The operation can be performed under spinal or general anaesthesia.

Results

The video illustrates a step-by-step performance of the technique, highlighting anatomical clarity and technical feasibility. The suture fixation technique shown has previously demonstrated long-term durability in published follow-up data (Klapdor et al., 2017). Initial clinical application revealed minimal blood loss, no intra- or postoperative complications, and rapid postoperative recovery.

Conclusions

This vNOTES-based uterosacropexy technique combines the biomechanical benefits of sacral fixation with the advantages of minimally invasive transvaginal access. It represents a promising mesh-free alternative for apical prolapse repair. Prospective clinical studies with larger cohorts are currently underway to evaluate long-term outcomes and patient satisfaction.

Informed consent was obtained from the patient for the publication of this video and accompanying text.

<https://player.vimeo.com/video/1085693882?autoplay=1>

Surgical Technique of Laparoscopic Mesh-less Pectopexy for Uterine Prolapse

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Background

To describe the surgical steps of laparoscopic Pectopexy without the use of a mesh.

Methods

Narrated surgical video. Local institutional review approval not required, patient consent was obtained.

47-year-old, multiparous patient was admitted to hospital with abnormal uterine bleeding and a 6-centimeter uterine fibroid. She also had pelvic organ prolapse and her POPQ score was as follows; Aa: -1, Ba: +1, C: +2, Ap: -1, Bp: -2, D: -1.

Results

After routine laparoscopic hysterectomy and bilateral salpingo-oophorectomy, meshless Pectopexy was performed to correct apical prolapse. Meshless Pectopexy can be performed safely by following those steps: 1. Peritoneal incision from the right end of the vaginal cuff to the level of the right pectineal ligament. 2. Identification of the pectineal ligament lateral to the medial umbilical ligament on the right side. 3. Repetition of steps 1 and 2 on the opposite side. 4. Passing of a non-absorbable monofilament polypropylene suture (Prolene 0, Ethicon Inc; Johnson & Johnson, Somerville, NJ, USA) through the pectineal ligament and knotting on one side. 5. Passing the suture through the vaginal cuff two or three times and tying with sufficient tension. 6. Repetition of steps 4 and 5 on the opposite side. 7. Closure of the parietal peritoneum with absorbable, knotless suture (V-loc™, Covidien, Inc, Mansfield, Massachusetts).

Conclusions

Laparoscopic Pectopexy was developed as an alternative method to sacrocolpopexy. In the original method, the cervix uteri or vaginal cuff is suspended to the bilateral pectineal ligament using a mesh. The use of mesh poses risks such as that of erosion. Some modifications of the original technique using Mersilene tape or polyester sutures instead of a mesh to prevent erosion have been described. However, data are limited. The meshless modification of laparoscopic Pectopexy with prolene sutures is a safe and reproducible method, eliminating the risk of mesh erosion, especially in cases with simultaneous hysterectomy.

<https://player.vimeo.com/video/1085661196?autoplay=1>

Efficacy of hysteroscopic resection in the treatment of recurrent endometrial hyperplastic processes

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Background

To assess the clinical efficacy of hysteroscopic resection in recurrent endometrial hyperplastic processes based on a three-year follow-up.

Endometrial hyperplastic processes (EHP) represent a common pathology among women of reproductive and perimenopausal age. treatment strategy depends on age, reproductive plans, and the type of hyperplasia. hysteroscopic resection not only allows for the removal of pathologically altered endometrium but also enables targeted biopsy, ensuring high diagnostic accuracy and minimal trauma.

Methods

Forty-six women aged 32 to 48 years with a diagnosis of recurrent endometrial hyperplasia were observed. all patients underwent hysteroscopic resection. clinical and histological monitoring was carried out for 36 months. the frequency of relapses, complications, and reproductive outcomes were evaluated.

Research site: oxygen clinic, Azerbaijan number of patients: 46 age: from 32 to 48 years, average — 40.1 ± 4.6 years simple glandular hyperplasia — 32 cases (69.6%) glandular-cystic hyperplasia — 14 cases (30.4%) treatment method: hysteroscopic resection under intravenous anaesthesia using a resectoscope (Karl Storz) observation period: 2021–2024 follow-up: ultrasound, histology, consultations at 3, 6, 12, 24, and 36 months

Results

Stable remission was achieved in 39 patients (84.8%). in 4 cases (8.7%) a relapse of the disease was observed, requiring repeat intervention. 3 women (6.5%) with atypical hyperplasia underwent hysterectomy. among patients of reproductive age (n=14), 3 pregnancies were recorded, 2 of which ended in childbirth.

Complete remission — 39 (84.8%) relapse — 4 (8.7%) hysterectomy due to atypia — 3 (6.5%) reproductive outcomes — 3 pregnancies, 2 births complications — 1 case of perforation, 1 case of inflammation

Conclusions

Hysteroscopic resection is an effective, minimally invasive, and uterus-preserving method for the treatment of endometrial hyperplasia. the method allows for a high rate of remission and favourable reproductive outcomes during long-term follow-up.

Hysteroscopic resection is a valuable uterus-preserving method for the treatment of endometrial hyperplasia. with proper technique and patient selection, it demonstrates high efficacy, a low rate of complications, and favourable reproductive prospects.

Sacrospinofixation: The Role of Hysteroscopy in Vaginal Surgery

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Background

First described by Richter in 1968, sacrospinofixation is a vaginal surgical technique used to treat vaginal vault prolapse. This procedure can be performed alone or in conjunction with a hysterectomy, cystocele repair, and rectocele repair to address multiple levels of pelvic prolapse. Despite the anatomical constraints, it remains a key approach in treating prolapse via the vaginal route.

This film aims to demonstrate the traditional surgical technique and highlight the contribution of hysteroscopy in identifying the sacrospinous ligament during the procedure.

Methods

The operation may be performed under general or regional anaesthesia. After disinfection with an antiseptic, a sterile field is set. A urinary catheter is not always necessary and depends on whether a hysterectomy or cystocele repair is planned.

Results

Following a vaginal hysterectomy, a scissor dissection is performed in the right rectovaginal space to separate the vaginal mucosa from the rectum, which is pushed aside manually. The pararectal space is palpated until the ischial spine is located posteriorly and laterally. Finger dissection continues to identify the sacrospinous ligament for anchoring. The hysteroscope is then used to enhance visualization of the ligament and its trajectory, avoiding adjacent vascular and neural structures. The instrument is guided along the surgeon's finger and positioned just beyond the ischial spine on the ligament. A non-absorbable suture (preferably polypropylene) is used to minimize postoperative complications. After confirming anchorage stability, sutures are passed retrograde through the vaginal vault apex. Each suture is identified separately. Colporrhaphy is initiated before final tightening of the structure. The correction is assessed, and colporrhaphy is completed once the setup is secured.

Conclusions

Using hysteroscopy to identify and guide the sacrospinous ligament improves anatomical visibility and reduces the risk of injury to adjacent structures

<https://player.vimeo.com/video/1090679064?autoplay=1>

Extreme intrauterine surgery: three steps hysteroscopic approach to treat a 4 cm fibroid in a complete uterine septum with partial cervical septum

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Background

Background: Uterine septum is the most common congenital anomaly of the female genital tract. It is rarely associated with septate cervix, representing a genital anomaly classified as U2bC1V0 according to ESHRE/ESGE classification. In rare cases, uterine septum can coexist with a uterine fibroid within the septum itself. Managing these rare conditions presents significant challenges. This video aims to demonstrate the feasibility of a three-step hysteroscopic approach to restore the uterus in a patient with partial cervical septum, complete uterine septum, and 4 cm fibroid within the septum.

Methods

Methods: We describe the case of a 37-year-old infertile woman with a congenital uterine anomaly classified as U2bC1V0, complicated by a 4 cm fibroid within the uterine septum. The procedures were performed at the Digital Hysteroscopic Clinic, Fondazione Policlinico Gemelli IRCCS in Rome, Italy. Preoperative assessment included a one-stop diagnostic workup with 2D/3D transvaginal ultrasound and hysteroscopy.

Results

Results: To address both the uterine anomaly and the fibroid, a three-step hysteroscopic approach was employed. The first surgery involved the incision of the cervical septum and partial resection of the uterine septum until the fibroid plane was reached, using the Collins loop of a 15 Fr bipolar mini-resectoscope, followed by the first step of myomectomy with a 90° angled loop on a 26 Fr bipolar resectoscope. The second surgery was performed to complete the myomectomy. A third procedure was carried out using a 15 Fr bipolar mini-resectoscope to perform metroplasty. No complications occurred during the surgeries. The patient was discharged three hours postoperatively after each procedure. Hysteroscopic control after the last surgery revealed a normal cervix and a normally shaped uterine cavity, with no intrauterine adhesions or residual fibroid tissue.

Conclusions

Conclusions: A multidisciplinary approach and the expertise of experienced surgeons are essential for managing rare and complex cases, minimizing complications, and achieving optimal surgical outcomes.

<https://player.vimeo.com/video/1090255092?autoplay=1>

Office hysteroscopic myomectomies in a tertiary hospital in Madrid: a retrospective observational study

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¹La Paz University Hospital, Gynecology, Madrid, Spain

Background

The main objective is analysing hysteroscopic myomectomies performed in an ambulatory setting in a tertiary hospital in Madrid (Spain), assessing the decrease in surgical procedures in recent years and the outcomes in terms of patient progress and satisfaction.

Methods

A retrospective observational study was conducted between 2020 and 2024. The study includes patients treated in the Hysteroscopy Unit who underwent office hysteroscopic myomectomies. The data collected includes age, number, type, and size of fibroids, pain evaluation by Visual Analogue Scale (VAS), number of procedures required and outcomes. A descriptive analysis of the data was subsequently carried out.

Results

A total of 148 office hysteroscopic myomectomies were performed between 2020 and 2024. The average age of the patients was 45.52 years. The main symptom leading to consultation was heavy menstrual bleeding in 84.5% of cases. In 3.42% of cases, the reason for consultation was postmenopausal metrorrhagia, and in another 3.42%, other causes such as hypogastric pain or dysmenorrhea. However, 8.21% of patients were asymptomatic, and the presence of a submucosal fibroid was detected during routine ultrasound.

Regarding the type and size of the fibroids, the most common was FIGO type 2, representing 48.48% of cases, followed by type 1 (38.78%) and type 0 (7.87%). The average size of the removed fibroids was 3.20 centimetres (cm). 42.70% of these fibroids were larger than 3 cm.

The average number of office procedures required to achieve complete myomectomy was 1.60. The materials used for the myomectomy included the mechanical hysteroscopic morcellator and the bipolar electrode. In 77.70% of cases, the procedure was successfully completed using only the morcellator. All patients were discharged right after the procedure and no major complications were reported.

After the hysteroscopy, patients completed a questionnaire to assess pain using the VAS. The average score obtained was 5.68, with 51.93% of patients reporting a pain score equal to or less than 5.

Subsequently, follow-up is conducted in the gynecology clinic. A total of 78.76% of patients had a satisfactory evaluation with improvement in abnormal menstrual bleeding, and symptoms persisted in only 10.95% of cases. In 10 cases (6.84%), surgical treatment with hysterectomy was necessary due to the presence of uterine myomatosis with persistent bleeding or associated symptoms caused by compression of adjacent organs by subserosal/intramural fibroids.

Conclusions

Hysteroscopic myomectomy in ambulatory setting offers comparable clinical outcomes to those of surgical myomectomy without significantly increasing the level of pain perceived by patients and reducing patient's discomfort. The main advantage is that it enables patients to immediately resume their normal daily activities, enhancing the overall patient experience and optimizing healthcare resource use. Furthermore, it is a more cost-effective alternative to the procedure performed in the operating room, as it does not require hospital admission or surgical resources.

Hysteroscopic Intrauterine Bigatti Shaver (IBS) for Treatment of G2-3 Submucosal Myomas in Reproductive-Aged Women: A 30-Case Clinical Analysis

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Background

This retrospective cohort study evaluated the procedural efficacy, perioperative safety, and reproductive outcomes following hysteroscopic Intrauterine Bigatti Shaver (IBS[®]) resection for managing G 2-3 submucosal myomas in reproductive-aged women.

Methods

Thirty patients (mean age: 31.0 ± 4.5 years) with 37 G2-3 submucosal myomas (mean diameter 2.2 cm, range 1.5-3.6 cm) undergoing IBS resection at Renji Hospital, Shanghai Jiao Tong University School of Medicine between January 2022 and May 2023 were analysed. The diagnosis was suspected at 2D transvaginal ultrasound and confirmed by a diagnostic hysteroscopy with the Campo Trophy-scope. All patients were treated with the 24Fr Intrauterine Bigatti Shaver (IBS[®]), with intrauterine adhesions were evaluated by diagnostic hysteroscopy after 1 month postoperatively.

Results

1. **Operative Outcomes:** Mean operative duration: 17 minutes (range 8-30), One step resection rate: 93.3% (28/30) , Two cases required two-step procedures due to large fibroid size (3.2 cm and 3.5 cm, respectively) with dense consistency and excessive fluid absorption (2,500 mL deficit).
2. **Safety Profile:** Mean fluid deficit: 1,200 mL (500-2,500). No major complication like fluid overload or uterine perforation significant hemorrhage (>200 mL), or postoperative infection occurred
3. **Postoperative Recovery:** All patients achieved same-day discharge (1-hour post-procedure). Office hysteroscopy at one month follow-up demonstrated complete endometrial restoration with no intrauterine adhesions. Significant reduction in menstrual blood loss.
4. **Reproductive Outcomes:** Among 21 conception-seeking patients after operation, 76.2% (16/21) achieved clinical pregnancy within 12 months. Pregnancy outcomes: 13 term deliveries (81.3%) and 3 first-trimester losses (18.7%).

Conclusions

Hysteroscopic IBS mechanical resection represents an effective and safe approach for managing G2-3 submucosal myomas, demonstrating high single-procedure success rates, favourable safety parameters, and excellent reproductive outcomes. These findings support its adoption as a good surgical option for fertility-preserving management of submucosal myomas in reproductive-aged populations.

**ESGE34-1004 -
Free Communication**

The role of robotic surgery in overcoming the challenges and treating complications of abdominal surgery in complex deep endometriosis (DE)

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Background

With the expansion in provision of robotic-assisted surgery (RAS), minimal access surgery is fast becoming the principal surgical approach for gynaecological surgery, in even the most complex of cases.¹

Methods

We present the application of our robotic gynaecological surgery programme in the management of a large, space-occupying Pouch of Douglas (PoD) peritoneal inclusion cyst, in a forty-one-year-old woman with a complex surgical history, and primary subfertility, dysmenorrhoea, debilitating urinary symptoms and dyschezia. She previously underwent an infra-umbilical midline laparotomy for intended myomectomy, abandoned intraoperatively due to significant bowel adhesions, sustaining a blood loss of 2.7L and further complicated by significant post-operative infection.

Preoperative imaging demonstrated a multi-fibroid uterus, left endometrioma and hydrosalpinx, a 15cm PoD cyst causing significant pressure effect, with the right ovary not visible separately but an eccentric adjacent 5.3cm solid/cystic lesion and further 3cm cyst, with a posterior uterine plaque of endometriosis creating a bilateral adnexal and rectal complex, with associated rectal disease. CT urogram showed compression of the bladder and bilateral distal ureters, though, normal renal function; her AMH was 3.0 pmol/L.

During RAS, treatment for DE was concurrently undertaken. After diligent preparation, the patient underwent cystoscopy with bilateral ureteric ICG injection, hysteroscopy with endometrial biopsy, extensive adhesiolysis, ethanol sclerotherapy of bilateral endometriomas², complete excision of peritoneal inclusion cyst including total pelvic peritonectomy, opening of bilateral para-rectal spaces, deep rectal shave with oversewing of the bowel wall, and left salpingectomy.

Results

She made an excellent post-operative recovery with discharge on day three. At review on day five, she reported complete resolution of her urinary symptoms.

Conclusions

RAS offers significant benefits in overcoming the challenges of complex abdominal surgery pertaining to superior visualisation and manoeuvrability within the abdomino-pelvic cavity whilst utilising a minimal access approach. We encourage consideration of RAS in cases where abdominal surgery has traditionally been deemed necessary.

<https://player.vimeo.com/video/1090497554?autoplay=1>

Robotic Total Vaginectomy for Primary Vaginal Melanoma: A Surgical Video Presentation

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Background

Primary vaginal melanoma is an exceptionally rare malignancy, representing less than 5% of vaginal cancers, and is associated with poor prognosis. Surgical resection remains the mainstay of treatment, although there is no standardized management strategy. Most reported cases have been treated with open approaches. This video aims to demonstrate a fully robotic total vaginectomy and to provide a technical reference for broader adoption of this minimally invasive method.

Methods

A 79-year-old woman presented with a pigmented, nodular, and fragile lesion on the lateral wall of the distal third of the vagina, measuring approximately 2 cm. Histopathologic evaluation of the biopsy revealed poorly differentiated carcinoma. Preoperative PET-CT and MRI showed no regional or distant metastasis. Robotic total vaginectomy with sentinel lymph node dissection was planned and successfully performed.

Surgical steps:

- Injection of indocyanine green (ICG) (2 cc, 1.25 mg/mL) at the lesion base
- Placement of robotic trocars and docking
- Abdominal exploration followed by continuation under 8 mmHg insufflation
- Dissection of ipsilateral paravesical and pararectal spaces for sentinel lymph node identification
- Exposure and protection of ureter, obturator nerve, and vascular structures
- Fluorescence-guided excision of sentinel lymph node with capsule preservation
- Completion of right pelvic lymphadenectomy
- Dissection and sealing of bilateral vaginal and pudendal arteries
- Anterior and posterior edge dissection from bladder and rectum
- En bloc dissection of the vaginal wall up to the vestibulum and specimen removal (*Figure1*)
- Robotic suturing of the vulvar edge in anteroposterior orientation
- Hemostasis and closure



Results

The patient was discharged on postoperative day 5 without complications. Final pathology confirmed vaginal melanoma, FIGO Stage IC (2009), pT4bN0 (American Joint Committee on Cancer-AJCC 8th Edition Staging System), with clear surgical margins.

Conclusions

Robotic assistance facilitates safe and precise total vaginectomy in anatomically complex regions. This case represents, to our knowledge, the first fully robotic total vaginectomy involving both proximal and distal vaginal segments, and may support the broader implementation of this approach.

<https://player.vimeo.com/video/1090246906?autoplay=1>

Robotic assisted vagino-vaginal anastomosis for complex obstructive Müllerian duct malformation

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Background

Transverse vaginal septum is a rare congenital malformation of the female genital tract, resulting from incorrect fusion or canalization of the Müllerian ducts. Its prevalence is 1/30000-50000 women and is often associated with dysmenorrhea, chronic pelvic pain, hematometra and hematocolpos. Diagnosis relies on ultrasound and magnetic resonance imaging while the primary treatment is Surgical removal of the septum and reconstruction of the vaginal tract. Our case concerns a 26-year-old patient who came to the emergency room because of worsening chronic pelvic pain, with an history of two hematocolpos drainages about 10 years ago.

Methods

After a careful study of the patient's anatomy, it was decided to intervene surgically using robotic surgery under hysteroscopic guidance. An intraoperative ultrasound and a hysteroscopy check was performed and they showed the absence of a communication tract between the two hemivagina. After docking the robot, pelvic examination revealed an enlarged uterus due to the presence of hematometra. Then the anterior and posterior compartment were prepared. Under ultrasound guidance, the vagina was incised in its upper third with a discharge of brown-dark red gelatinous fluid from the uterine cavity. Under hysteroscopic guidance, the cervix and endometrial cavity were visualized and the transverse vaginal septum was guidance, the detached stitch vaginovaginal anastomosis was performed and the round ligaments were reconstructed.

Results

Robotic surgery allowed us to perform an extremely precise vaginovaginal anastomosis, hysteroscopy allowed us to correctly identify the anatomical landmarks to perform anastomosis, hysteroscopy hysteroscopic check-up after 30 and 90 days showed a total restoration of normal vaginal anatomy.

Conclusions

The case demonstrates how accurate diagnosis and timely treatment in a level III centre, allow patient access to advanced technologies and a multidisciplinary team. This approach ensures optimal outcomes in a short period time. The restoration of the patient's normal vaginal anatomy significantly improved her quality of life and future reproductive prospects.

<https://player.vimeo.com/video/1090104012?autoplay=1>

Robotic Excision of Uterine Horns in Paediatric-Adolescent Gynaecology Patients: A Case Series

Kelly Haldane¹, William Farkas¹, Naomi Crouch¹, Oliver O'Donovan¹

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Background

This video presentation outlines a case series using robotic-assisted surgery to manage obstructed uterine horns in the paediatric-adolescent gynaecology (PAG) population. It highlights the importance of a multidisciplinary approach in a tertiary care setting for optimising outcomes in rare, complex congenital anomalies. Following the development of robotic skills, the surgical team sought to apply the advantages of robotics—enhanced dexterity, visualisation, and access—to this cohort.

Methods

Four patients aged 14 to 19 were evaluated in a specialised PAG clinic with established expertise in laparoscopic management of Müllerian anomalies. Preoperative MRI was used to identify the affected uterine horn and assess renal anatomy. Each case underwent multidisciplinary review involving radiologists, PAG consultants, and minimal access specialists.

Results

All surgeries were performed in adult operating theatres using robotic-assisted technology. The primary surgeon was a consultant in endometriosis and minimal access surgery, supported by a PAG consultant and a paediatric-trained anaesthetist experienced in robotic procedures. Surgical innovations included the use of vasopressin (Pitressin) and indocyanine green (ICG) to enhance intraoperative visualisation. None of the procedures required suturing, and all patients were discharged on the same day without complications.

Conclusions

Robotically assisted excision of uterine horns in PAG patients represents a novel and innovative approach. To our knowledge, this is the first reported use of robotic-assisted excision of uterine horns in the UK paediatric-adolescent population. Robotic surgery offers the potential to match or surpass traditional laparoscopic outcomes, particularly for cases that may require myometrial and serosal closure in the future. The collaborative approach between paediatric and adolescent gynaecologists and advanced minimal access surgeons was instrumental to the success of these interventions.

These cases emphasise the value of centralising care for complex gynaecological anomalies within NHS England-recognised centres, where multidisciplinary expertise and access to advanced technology support optimal outcomes and the evolution of minimally invasive approaches in PAG.

<https://player.vimeo.com/video/1090094682?autoplay=1>

Robotic Management of Delayed Ureteral Injury After Laparoscopic Hysterectomy

Ahmet Furkan Sarikaya¹, Serdar Aydın², Abdullah Erdem Canda¹

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²Koc University, Department of Obstetrics and Gynaecology, Istanbul, Turkiye

Background

Ureteral injury is a rare but significant complication of laparoscopic hysterectomy. We present a case of iatrogenic left distal ureteral obstruction following laparoscopic total abdominal hysterectomy (TAH), successfully managed with robotic-assisted ureteroneocystostomy.

Methods

A 42-year-old female with a history of two caesarean deliveries underwent laparoscopic TAH. The intraoperative course was uneventful; however, postoperative imaging revealed left-sided hydronephrosis. Abdominal MRI demonstrated diffuse thickening and fibrosis of the distal left ureter at the level of iliac vessel crossing, with a diverticulum-like appearance and narrowing near the ureterovesical junction. Percutaneous nephrostomy was placed. Antegrade pyelography confirmed complete obstruction of the distal ureter with no contrast passage to the bladder after three minutes. We decided the patient underwent robotic-assisted left ureteroneocystostomy.

Results

The procedure was completed without intraoperative complications. Postoperatively, the patient remained hemodynamically stable. On postoperative day 2, she developed a transient fever, but urine and blood cultures showed no microbial growth. She was discharged on postoperative day 5 in good clinical condition. Her renal function was preserved throughout the course, with an eGFR of 119 ml/min/1.73 m². Follow-up X-ray and cystography demonstrated unobstructed urine flow with no evidence of vesicoureteral reflux.

Conclusions

Robotic-assisted ureteroneocystostomy offers a safe and effective solution for the management of distal ureteral injuries following Gynecologic laparoscopic procedures. Early diagnosis and a minimally invasive reconstructive approach can lead to favourable outcomes with preserved renal function.

<https://player.vimeo.com/video/1089942310?autoplay=1>

Robot-assisted Laparoscopic Excision of extensive bowel Endometriosis by Natural Orifice Specimen Extraction (NOSE)

Sami Shihada¹, Rami Shihada¹, Ruediger Klapdor¹

¹Albertinen Hospital, Department for Obstetrics and Gynecology, Hamburg, Germany

Background

Optimizing operative results and recovery time for young patients with extensive deep infiltrating endometriosis, especially with bowel involvement.

Methods

Robotic surgery for deep infiltrating endometriosis with segmental resection by natural orifice specimen extraction (total minimal invasive approach).

Results

We performed a successful totally minimal invasive procedure by NOSE for large bowel nodule on the rectosigmoid.

Conclusions

In comparison to other approaches the NOSE technique is a good alternative in operative bowel segmental resection, especially when performed by robotics. Even in cases with large bowel involvement like in the case shown.

<https://player.vimeo.com/video/1085808943?autoplay=1>

Surgical treatment of endometrial cancer in morbidly obese patients. Comparison of laparoscopic and robot-assisted access (preliminary results).

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¹Moscow Regional Scientific Research Institute of Obstetrics and Gynecology named after academician V.I. Krasnopolsky-, Department of operative gynecology with Oncogynecology, Moscow, Russia

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Background

It is known that excessive body weight is the main risk factor of endometrioid type endometrial cancer (EC) development, but the issue of treatment of patients with pronounced obesity remains relevant and debatable even nowadays. Conventional laparoscopy, which has high-level and comparable oncologic results in groups of patients with body mass index (BMI) < 35 kg/m², is characterized by an increase in the laparoconversion rate up to 57% at BMI > 40 kg/m², leading to an increase in the number of complications and increasing the cost of treatment by 33%. Robot-assisted laparoscopic access creates all the necessary conditions for successful surgical treatment of such patients. Now, there are no domestic publications comparing the results of laparoscopic and robot-assisted access in morbidly obese patients, and the RObese study, which began in 2023, plans to publish preliminary results in 2026. In our study we compared the operation time, blood loss volume, duration of hospitalization, adequacy of the performed surgical volume, intraoperative and postoperative complications at laparoscopic and robot-assisted panhysterectomy in combination or without pelvic lymphadenectomy in surgical treatment of morbid obese patients.

Methods

A retrospective analysis of clinical characteristics, treatment, and one-stage comparative study of 124 patients suffering from morbid obesity treated based on Moscow Regional Scientific Research Institute of Obstetrics and Gynecology named after academician V.I. Krasnopolsky, Moscow, Russian Federation in the period from 2015 to 2022 was carried out. The patients were divided into two groups. The 1st group consisted of women operated by laparoscopic access (n=46), the 2nd group (n=76) - by robotic access.

Results

Medical records of 281 patients diagnosed with endometrial cancer (C54.1) were analysed according to individual and group medical records (case histories, reports). Of these, 124 (44.1%) women had morbid obesity (mean BMI for both groups was 48.7 kg/m², respectively). We found no statistically significant differences in operation time, amount of blood loss, number of removed lymph nodes, duration of hospitalization, number of intraoperative and postoperative complications. There was only one case of laparoconversion in the robotic access group due to bleeding, but it should be noted that the patient had an extremely high BMI > 53 kg/m². Pelvic lymphadenectomy was performed in 6 (13.0%) patients in group 1 and 15 (19.7%) patients in group 2. The mean BMI of patients in group 1 who underwent lymphadenectomy was 37.5 kg/m², in group 2 - 47.9 kg/m² respectively.

Conclusions

Robot-assisted laparoscopy is safe in the treatment of endometrial cancer in morbidly obese patients: the obtained results are comparable with the results of standard laparoscopy, nevertheless, the robotic system allows to perform surgical treatment with a higher probability in the full volume in the conditions of morbid obesity.

Robot-Assisted Laparoscopic Excision of Deep Infiltrating Endometriosis with Dissection of Atypical Gluteal Vessels and Lumbosacral Plexus Neurolysis

Sarah Bryan¹, Rüdiger Klapdor¹

¹Albertinen Hospital, Obstetrics and Gynaecology, Hamburg, Germany

Background

This video demonstrates the surgical technique and anatomical considerations involved in the robot-assisted laparoscopic excision of deep infiltrating endometriosis (DIE), with particular focus on the identification and management of atypical gluteal vasculature compressing the lumbosacral plexus in a patient presenting with severe dysmenorrhea and radiculopathy.

Methods

The 34-year-old patient presented with clinical signs for DIE and cyclical radiculopathy involving the lower back, right leg, and foot - consistent with lumbosacral plexus involvement (L5/S1/S2). A robot-assisted laparoscopic approach was employed. Key steps include retroperitoneal dissection extending to the obturator fossa, targeted neurolysis of the right lumbosacral plexus and identification, preparation and coagulation of the atypical inferior gluteal vessels compressing the sciatic and superior gluteal nerves. This allowed for successful neural exposure and decompression.

Results

Surgical findings confirmed DIE involving the right uterosacral ligament; however, intraoperative dissection revealed that vascular anomalies were the primary cause of nerve compression (#ENZIAN classification: P3 B0/2 FA). Meticulous vascular dissection, precise coagulation and targeted neurolysis enabled successful decompression of the affected nerves, without compromising neural function. A levonorgestrel intrauterine system (Mirena®) was placed for endometriosis prophylaxis and pregabalin was prescribed for the management of neuropathic pain. Postoperative recovery was uneventful.

Conclusions

This case illustrates the feasibility and effectiveness of robot-assisted nerve-sparing surgery for DIE and pelvic nerve entrapment. The video highlights critical elements of pelvic neuroanatomy, as well as the importance of safe dissection near neural structures and tailored management in cases with unexpected anatomical abnormalities. Viewers should focus on neurovascular identification and precise resection techniques as strategies for achieving complete decompression without nerve injury.

<https://player.vimeo.com/video/1084609781?autoplay=1>

The role of robotic surgery in overcoming the challenges and treating complications of abdominal surgery in complex deep endometriosis (DE)

Sangeetha Nagenthiran¹, Sarah Bennet¹, Alba Bajrami¹, Tom Bainton¹, Jeffrey Ahmed¹, Manou Manpreet Kaur¹
¹Chelsea Centre for Robotic Gynaecology- Chelsea & Westminster Hospital, Gynaecology, London, United Kingdom

Background

With the expansion in provision of robotic-assisted surgery (RAS), minimal access surgery is fast becoming the principal surgical approach for gynaecological surgery, in even the most complex of cases.¹

Methods

We present the application of our robotic gynaecological surgery programme in the management of a large, space-occupying Pouch of Douglas (PoD) peritoneal inclusion cyst, in a forty-one-year-old woman with a complex surgical history, and primary subfertility, dysmenorrhoea, debilitating urinary symptoms and dyschezia. She previously underwent an infra-umbilical midline laparotomy for intended myomectomy, abandoned intraoperatively due to significant bowel adhesions, sustaining a blood loss of 2.7L and further complicated by significant post-operative infection.

Preoperative imaging demonstrated a multi-fibroid uterus, left endometrioma and hydrosalpinx, a 15cm PoD cyst causing significant pressure effect, with the right ovary not visible separately but an eccentric adjacent 5.3cm solid/cystic lesion and further 3cm cyst, with a posterior uterine plaque of endometriosis creating a bilateral adnexal and rectal complex, with associated rectal disease. CT urogram showed compression of the bladder and bilateral distal ureters, though, normal renal function; her AMH was 3.0 pmol/L.

During RAS, treatment for DE was concurrently undertaken. After diligent preparation, the patient underwent cystoscopy with bilateral ureteric ICG injection, hysteroscopy with endometrial biopsy, extensive adhesiolysis, ethanol sclerotherapy of bilateral endometriomas², complete excision of peritoneal inclusion cyst including total pelvic peritonectomy, opening of bilateral para-rectal spaces, deep rectal shave with oversewing of the bowel wall, and left salpingectomy.

Results

She made an excellent post-operative recovery with discharge on day three. At review on day five, she reported complete resolution of her urinary symptoms.

Conclusions

RAS offers significant benefits in overcoming the challenges of complex abdominal surgery pertaining to superior visualisation and manoeuvrability within the abdomino-pelvic cavity whilst utilising a minimal access approach. We encourage consideration of RAS in cases where abdominal surgery has traditionally been deemed necessary.

<https://player.vimeo.com/video/1090497554?autoplay=1>

Robotic Total Vaginectomy for Primary Vaginal Melanoma: A Surgical Video Presentation

Fatma Başak Sargın¹, Mehtap Kirtzali¹, Mehmet Murat Naki¹

¹Medipol Acibadem District Hospital, obstetrics and gynecology, Istanbul, Turkiye

Background

Primary vaginal melanoma is an exceptionally rare malignancy, representing less than 5% of vaginal cancers, and is associated with poor prognosis. Surgical resection remains the mainstay of treatment, although there is no standardized management strategy. Most reported cases have been treated with open approaches. This video aims to demonstrate a fully robotic total vaginectomy and to provide a technical reference for broader adoption of this minimally invasive method.

Methods

A 79-year-old woman presented with a pigmented, nodular, and fragile lesion on the lateral wall of the distal third of the vagina, measuring approximately 2 cm. Histopathologic evaluation of the biopsy revealed poorly differentiated carcinoma. Preoperative PET-CT and MRI showed no regional or distant metastasis. Robotic total vaginectomy with sentinel lymph node dissection was planned and successfully performed.

Surgical steps:

- Injection of indocyanine green (ICG) (2 cc, 1.25 mg/mL) at the lesion base
- Placement of robotic trocars and docking
- Abdominal exploration followed by continuation under 8 mmHg insufflation
- Dissection of ipsilateral paravesical and pararectal spaces for sentinel lymph node identification
- Exposure and protection of ureter, obturator nerve, and vascular structures
- Fluorescence-guided excision of sentinel lymph node with capsule preservation
- Completion of right pelvic lymphadenectomy
- Dissection and sealing of bilateral vaginal and pudendal arteries
- Anterior and posterior edge dissection from bladder and rectum
- En bloc dissection of the vaginal wall up to the vestibulum and specimen removal (*Figure1*)
- Robotic suturing of the vulvar edge in anteroposterior orientation
- Hemostasis and closure



Results

The patient was discharged on postoperative day 5 without complications. Final pathology confirmed vaginal melanoma, FIGO Stage IC (2009), pT4bN0 (American Joint Committee on Cancer-AJCC 8th Edition Staging System), with clear surgical margins.

Conclusions

Robotic assistance facilitates safe and precise total vaginectomy in anatomically complex regions. This case represents, to our knowledge, the first fully robotic total vaginectomy involving both proximal and distal vaginal segments, and may support the broader implementation of this approach.

<https://player.vimeo.com/video/1090246906?autoplay=1>

Robotic assisted vagino-vaginal anastomosis for complex obstructive Müllerian duct malformation

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Background

Transverse vaginal septum is a rare congenital malformation of the female genital tract, resulting from incorrect fusion or canalization of the Müllerian ducts. Its prevalence is 1/30000-50000 women and is often associated with dysmenorrhea, chronic pelvic pain, hematometra and hematocolpos. Diagnosis relies on ultrasound and magnetic resonance imaging while the primary treatment is Surgical removal of the septum and reconstruction of the vaginal tract. Our case concerns a 26-year-old patient who came to the emergency room because of worsening chronic pelvic pain, with an history of two hematocolpos drainages about 10 years ago.

Methods

After a careful study of the patient's anatomy, it was decided to intervene surgically using robotic surgery under hysteroscopic guidance. An intraoperative ultrasound and a hysteroscopy check was performed and they showed the absence of a communication tract between the two hemivagina. After docking the robot, pelvic examination revealed an enlarged uterus due to the presence of hematometra. Then the anterior and posterior compartment were prepared. Under ultrasound guidance, the vagina was incised in its upper third with a discharge of brown-dark red gelatinous fluid from the uterine cavity. Under hysteroscopic guidance, the cervix and endometrial cavity were visualized and the transverse vaginal septum was guidance, the detached stitch vaginovaginal anastomosis was performed and the round ligaments were reconstructed.

Results

Robotic surgery allowed us to perform an extremely precise vaginovaginal anastomosis, hysteroscopy allowed us to correctly identify the anatomical landmarks to perform anastomosis, hysteroscopy hysteroscopic check-up after 30 and 90 days showed a total restoration of normal vaginal anatomy.

Conclusions

The case demonstrates how accurate diagnosis and timely treatment in a level III centre, allow patient access to advanced technologies and a multidisciplinary team. This approach ensures optimal outcomes in a short period time. The restoration of the patient's normal vaginal anatomy significantly improved her quality of life and future reproductive prospects.

<https://player.vimeo.com/video/1090104012?autoplay=1>

Robotic Excision of Uterine Horns in Paediatric-Adolescent Gynaecology Patients: A Case Series

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Background

This video presentation outlines a case series using robotic-assisted surgery to manage obstructed uterine horns in the paediatric-adolescent gynaecology (PAG) population. It highlights the importance of a multidisciplinary approach in a tertiary care setting for optimising outcomes in rare, complex congenital anomalies. Following the development of robotic skills, the surgical team sought to apply the advantages of robotics—enhanced dexterity, visualisation, and access—to this cohort.

Methods

Four patients aged 14 to 19 were evaluated in a specialised PAG clinic with established expertise in laparoscopic management of Müllerian anomalies. Preoperative MRI was used to identify the affected uterine horn and assess renal anatomy. Each case underwent multidisciplinary review involving radiologists, PAG consultants, and minimal access specialists.

Results

All surgeries were performed in adult operating theatres using robotic-assisted technology. The primary surgeon was a consultant in endometriosis and minimal access surgery, supported by a PAG consultant and a paediatric-trained anaesthetist experienced in robotic procedures. Surgical innovations included the use of vasopressin (Pitressin) and indocyanine green (ICG) to enhance intraoperative visualisation. None of the procedures required suturing, and all patients were discharged on the same day without complications.

Conclusions

Robotically assisted excision of uterine horns in PAG patients represents a novel and innovative approach. To our knowledge, this is the first reported use of robotic-assisted excision of uterine horns in the UK paediatric-adolescent population. Robotic surgery offers the potential to match or surpass traditional laparoscopic outcomes, particularly for cases that may require myometrial and serosal closure in the future. The collaborative approach between paediatric and adolescent gynaecologists and advanced minimal access surgeons was instrumental to the success of these interventions.

These cases emphasise the value of centralising care for complex gynaecological anomalies within NHS England-recognised centres, where multidisciplinary expertise and access to advanced technology support optimal outcomes and the evolution of minimally invasive approaches in PAG.

<https://player.vimeo.com/video/1090094682?autoplay=1>

Robotic Management of Delayed Ureteral Injury After Laparoscopic Hysterectomy

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Background

Ureteral injury is a rare but significant complication of laparoscopic hysterectomy. We present a case of iatrogenic left distal ureteral obstruction following laparoscopic total abdominal hysterectomy (TAH), successfully managed with robotic-assisted ureteroneocystostomy.

Methods

A 42-year-old female with a history of two caesarean deliveries underwent laparoscopic TAH. The intraoperative course was uneventful; however, postoperative imaging revealed left-sided hydronephrosis. Abdominal MRI demonstrated diffuse thickening and fibrosis of the distal left ureter at the level of iliac vessel crossing, with a diverticulum-like appearance and narrowing near the ureterovesical junction. Percutaneous nephrostomy was placed. Antegrade pyelography confirmed complete obstruction of the distal ureter with no contrast passage to the bladder after three minutes. We decided the patient underwent robotic-assisted left ureteroneocystostomy.

Results

The procedure was completed without intraoperative complications. Postoperatively, the patient remained hemodynamically stable. On postoperative day 2, she developed a transient fever, but urine and blood cultures showed no microbial growth. She was discharged on postoperative day 5 in good clinical condition. Her renal function was preserved throughout the course, with an eGFR of 119 ml/min/1.73 m². Follow-up X-ray and cystography demonstrated unobstructed urine flow with no evidence of vesicoureteral reflux.

Conclusions

Robotic-assisted ureteroneocystostomy offers a safe and effective solution for the management of distal ureteral injuries following Gynecologic laparoscopic procedures. Early diagnosis and a minimally invasive reconstructive approach can lead to favourable outcomes with preserved renal function.

<https://player.vimeo.com/video/1089942310?autoplay=1>

Robot-assisted Laparoscopic Excision of extensive bowel Endometriosis by Natural Orifice Specimen Extraction (NOSE)

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Background

Optimizing operative results and recovery time for young patients with extensive deep infiltrating endometriosis, especially with bowel involvement.

Methods

Robotic surgery for deep infiltrating endometriosis with segmental resection by natural orifice specimen extraction (total minimal invasive approach).

Results

We performed a successful totally minimal invasive procedure by NOSE for large bowel nodule on the rectosigmoid.

Conclusions

In comparison to other approaches the NOSE technique is a good alternative in operative bowel segmental resection, especially when performed by robotics. Even in cases with large bowel involvement like in the case shown.

<https://player.vimeo.com/video/1085808943?autoplay=1>

Surgical treatment of endometrial cancer in morbidly obese patients. Comparison of laparoscopic and robot-assisted access (preliminary results).

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Background

It is known that excessive body weight is the main risk factor of endometrioid type endometrial cancer (EC) development, but the issue of treatment of patients with pronounced obesity remains relevant and debatable even nowadays. Conventional laparoscopy, which has high-level and comparable oncologic results in groups of patients with body mass index (BMI) < 35 kg/m², is characterized by an increase in the laparoconversion rate up to 57% at BMI > 40 kg/m², leading to an increase in the number of complications and increasing the cost of treatment by 33%. Robot-assisted laparoscopic access creates all the necessary conditions for successful surgical treatment of such patients. Now, there are no domestic publications comparing the results of laparoscopic and robot-assisted access in morbidly obese patients, and the RObese study, which began in 2023, plans to publish preliminary results in 2026. In our study we compared the operation time, blood loss volume, duration of hospitalization, adequacy of the performed surgical volume, intraoperative and postoperative complications at laparoscopic and robot-assisted panhysterectomy in combination or without pelvic lymphadenectomy in surgical treatment of morbid obese patients.

Methods

A retrospective analysis of clinical characteristics, treatment, and one-stage comparative study of 124 patients suffering from morbid obesity treated based on Moscow Regional Scientific Research Institute of Obstetrics and Gynecology named after academician V.I. Krasnopolsky, Moscow, Russian Federation in the period from 2015 to 2022 was carried out. The patients were divided into two groups. The 1st group consisted of women operated by laparoscopic access (n=46), the 2nd group (n=76) - by robotic access.

Results

Medical records of 281 patients diagnosed with endometrial cancer (C54.1) were analysed according to individual and group medical records (case histories, reports). Of these, 124 (44.1%) women had morbid obesity (mean BMI for both groups was 48.7 kg/m², respectively). We found no statistically significant differences in operation time, amount of blood loss, number of removed lymph nodes, duration of hospitalization, number of intraoperative and postoperative complications. There was only one case of laparoconversion in the robotic access group due to bleeding, but it should be noted that the patient had an extremely high BMI > 53 kg/m². Pelvic lymphadenectomy was performed in 6 (13.0%) patients in group 1 and 15 (19.7%) patients in group 2. The mean BMI of patients in group 1 who underwent lymphadenectomy was 37.5 kg/m², in group 2 - 47.9 kg/m² respectively.

Conclusions

Robot-assisted laparoscopy is safe in the treatment of endometrial cancer in morbidly obese patients: the obtained results are comparable with the results of standard laparoscopy, nevertheless, the robotic system allows to perform surgical treatment with a higher probability in the full volume in the conditions of morbid obesity.

Robot-Assisted Laparoscopic Excision of Deep Infiltrating Endometriosis with Dissection of Atypical Gluteal Vessels and Lumbosacral Plexus Neurolysis

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Background

This video demonstrates the surgical technique and anatomical considerations involved in the robot-assisted laparoscopic excision of deep infiltrating endometriosis (DIE), with particular focus on the identification and management of atypical gluteal vasculature compressing the lumbosacral plexus in a patient presenting with severe dysmenorrhea and radiculopathy.

Methods

The 34-year-old patient presented with clinical signs for DIE and cyclical radiculopathy involving the lower back, right leg, and foot - consistent with lumbosacral plexus involvement (L5/S1/S2). A robot-assisted laparoscopic approach was employed. Key steps include retroperitoneal dissection extending to the obturator fossa, targeted neurolysis of the right lumbosacral plexus and identification, preparation and coagulation of the atypical inferior gluteal vessels compressing the sciatic and superior gluteal nerves. This allowed for successful neural exposure and decompression.

Results

Surgical findings confirmed DIE involving the right uterosacral ligament; however, intraoperative dissection revealed that vascular anomalies were the primary cause of nerve compression (#ENZIAN classification: P3 B0/2 FA). Meticulous vascular dissection, precise coagulation and targeted neurolysis enabled successful decompression of the affected nerves, without compromising neural function. A levonorgestrel intrauterine system (Mirena®) was placed for endometriosis prophylaxis and pregabalin was prescribed for the management of neuropathic pain. Postoperative recovery was uneventful.

Conclusions

This case illustrates the feasibility and effectiveness of robot-assisted nerve-sparing surgery for DIE and pelvic nerve entrapment. The video highlights critical elements of pelvic neuroanatomy, as well as the importance of safe dissection near neural structures and tailored management in cases with unexpected anatomical abnormalities. Viewers should focus on neurovascular identification and precise resection techniques as strategies for achieving complete decompression without nerve injury.

<https://player.vimeo.com/video/1084609781?autoplay=1>

Endometrial osseous metaplasia following surgical termination of pregnancy – A case report

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Background

Background: Endometrial osseous metaplasia is a rare clinical entity characterised by the presence of mature & immature bone in the endometrium. Management involves removing the bony fragments hysteroscopically but this can be a challenging procedure. We describe a case.

Methods

A 37-year-old woman referred seven months after late surgical termination of pregnancy at 22/40 weeks. She was being investigated for ongoing pelvic pain and abnormal bleeding. Outpatient hysteroscopy showed fragments of bone in the uterine cavity, and a subsequent MRI scan confirmed bone within the uterine cavity. Hysteroscopic removal of the bony fragments was planned.

Results

Procedure and results: Bony fragments were meticulously removed using conventional hysteroscopic grasping instruments (5Fr grasper and scissors). The anterior endometrium was minimally resected using electrosurgery for more deeply embedded bony spicules. HyeRegen gel (absorbable adhesion barrier gel) was instilled to prevent intrauterine adhesions. Intraoperative transvaginal ultrasound scan (TVS) confirmed no residual echogenicity suggestive of residual bone within the uterine cavity. Estrogen valerate 2 mg orally TDS and 2 mg vaginally OD was prescribed post-operatively for 6 weeks and Norethisterone 5 mg TDS on week 5 & 6 to help regenerate the endometrium and trigger a withdrawal bleed. An outpatient hysteroscopy was scheduled at 6 weeks and showed a clear cavity without adhesions. The patient is awaiting in vivo fertilisation treatment.

Conclusions

Endometrial osseous metaplasia is a rare condition that has a major adverse impact upon fertility. Hysteroscopic extraction is the current standard treatment. However, the prevalence of bony fragment regeneration and the future receptivity of the endometrium to facilitate implantation and successful pregnancy is unknown. More studies are needed to better understand the best way to follow up post-surgical patients, the role of further surgery based upon imaging, the success of natural conception and the timing of assisted reproductive techniques.

<https://player.vimeo.com/video/1090400716?autoplay=1>

The role of hysteroscopy in the diagnosis and management of placental polyps following abortion

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Background

Placental polyps are rare but significant complications that may arise after abortion, characterized by retained placental tissue forming a vascular mass within the endometrial cavity. The objective of this study is to evaluate the diagnostic accuracy, therapeutic efficacy, and fertility outcomes of hysteroscopy in the management of placental polyps compared to traditional methods such as blind curettage.

Methods

A retrospective and literature-based review was conducted, analysing cases of placental polyps diagnosed after first- or second-trimester abortion. We included patients presenting with abnormal uterine bleeding and confirmed diagnosis via hysteroscopy between 2018 and 2024. Diagnostic methods (transvaginal ultrasound, β -hCG levels, hysteroscopic findings), surgical approaches (operative hysteroscopy vs. curettage), intraoperative outcomes (blood loss, complications), and reproductive outcomes (adhesions, future pregnancies) were assessed.

Results

Among the reviewed cases, hysteroscopy demonstrated a superior diagnostic accuracy compared to ultrasound alone. Hysteroscopic visualization revealed typical features of placental polyps: vascular, friable intrauterine masses, often located on the fundus or posterior wall. In 90% of cases, hysteroscopic resection achieved complete removal in a single procedure. No major complications occurred, and intraoperative bleeding was minimal in most patients, with only 5% requiring adjunctive haemostatic measures. Compared to blind D&C, hysteroscopic management resulted in a significantly lower rate of incomplete evacuation (5% vs. 22%) and fewer postoperative adhesions (3% vs. 15%). Among patients desiring fertility, 87% achieved successful conception within one year postoperatively. Furthermore, hysteroscopy enabled accurate histopathological sampling, confirming the benign nature of retained tissue and ruling out neoplasia in all cases.

Conclusions

Hysteroscopy offers a safe, effective, and fertility-preserving approach for both the diagnosis and treatment of placental polyps following abortion. Its ability to directly visualize and precisely resect retained tissue minimizes complications associated with blind curettage and improves clinical outcomes. As minimally invasive Gynecologic surgery continues to evolve, hysteroscopy should be considered the first-line modality in managing suspected placental polyps, especially in women of reproductive age. ESGE should continue to promote training and access to hysteroscopic techniques as part of post-abortion care protocols.

Hysteroscopic Management of Intrauterine Adhesions and Submucous Myoma in a Patient with Secondary Amenorrhea

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Background

Intrauterine adhesions (IUA), or Asherman's syndrome, are fibrotic bands that form following endometrial trauma, particularly after curettage. With an estimated prevalence of 20% post-dilation and curettage (D&C), IUAs commonly present as secondary amenorrhea. Hysteroscopic adhesiolysis is the gold standard for treatment, with electrosurgery avoided to minimize endometrial injury. This video article demonstrates the hysteroscopic management of IUAs and a concurrent submucous myoma in a patient with secondary amenorrhea.

Methods

A 29-year-old woman (G1P0A1) presented with 4 months of secondary amenorrhea. Six months prior, she underwent two D&Cs for a missed abortion, with pathology confirming chorionic villi and excluding molar pregnancy. Hormonal evaluation was normal. Transvaginal ultrasound revealed IUAs and a 2.5 cm anterior submucous myoma. Diagnostic hysteroscopy confirmed dense adhesions, partially obliterating the cavity, alongside the myoma.

Under general anaesthesia, hysteroscopic adhesiolysis was performed using mechanical dissection to minimize thermal damage. The submucous myoma was resected hysteroscopically in a single procedure. Anti-adhesion barrier gel was applied postoperatively, and estrogen therapy was initiated to promote endometrial regeneration.

Results

A second-look hysteroscopy at 3 months showed a restored uterine cavity with patent tubal ostia. The patient resumed regular menses two months postoperatively, demonstrating both anatomical and functional success.

Conclusions

This case highlights the importance of hysteroscopy in diagnosing and treating IUAs while addressing concurrent pathology like submucous myomas. Mechanical adhesiolysis and anti-adhesion measures optimize outcomes, reducing recurrence risks. Early intervention and hormonal support are crucial for restoring menstrual function and fertility.

<https://player.vimeo.com/video/1090208861?autoplay=1>

An expanded classification proposal for Y-shaped uterus using 3D ultrasound criteria: surgical insights and reproductive impact

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Background

The classification of dysmorphic uteri remains a dynamic area in reproductive gynecology. Recently, Aslan et al. proposed diagnostic criteria using 3D transvaginal ultrasound imaging to identify Y-shaped uteri. However, standardized diagnostic parameters are still lacking. This study aims to evaluate the key measurements of five parameters for Y-shaped uteri proposed by Aslan to validate their criteria and develop an expanded classification system. Additionally, reproductive impact after hysteroscopic metroplasty was evaluated.

Methods

Patients with previous unfavourable reproductive outcome who received fundal and lateral bulging hysteroscopic corrections for Y-shaped dysmorphic uterus were retrospectively analysed. Five preoperative 3D ultrasound parameters proposed by Aslan were assessed. The 5th and the 95th percentiles were calculated for all five measurements. Post-operative reproductive outcomes in terms of clinical pregnancy rate (CPR), miscarriage rate (MR), and live birth rate (LBR) were compared between patients satisfying Aslan's criteria and those who did not.

Results

Fifty-one patients were included. Only 11/51 (21.6%) patients met the Aslan's criteria for Y-shaped uterus. Our expanded classification showed broader parameter intervals: lateral indentation depth 4-11 mm, lateral indentation angles 105°-147°, fundal indentation depth 4-10 mm, fundal indentation angle 118°-151°, and Y-angles 27°-61°. Thirty-six patients were included in the post-operative analysis. No statistically significant differences ($p > 0.05$) were observed for any of the post-metroplasty reproductive outcomes (CPR, LBR and MR) between patients who met Aslan criteria and those who did not.

Conclusions

Our findings support a broader classification system for Y-shaped uteri based on expanded ultrasound criteria proposed by Aslan. Larger prospective studies are needed to validate our proposal and establish a consensus among experts to identify the target population of women who could benefit from hysteroscopic correction.

Hysteroscopic Transcervical Resection of the Endometrium for Abnormal Uterine Bleeding - A Single Centre Experience

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Background

Abnormal uterine bleeding (AUB) affects women in their reproductive age group and has a significant impact on the social, physical, mental, and emotional health of the women. A recent Lancet study showed the prevalence of heavy menstrual bleeding in South Asian and sub-African countries to be high which impacts their quality of life. Hysterectomy is the definitive treatment of abnormal uterine bleeding. Transcervical resection of the endometrium (TCRE), a first-generation technique has been an accepted alternative to hysterectomy for the past 20 years. In most developed countries, second generation devices have replaced TCRE, but in developing countries TCRE is still being performed widely. The objective of the paper is to audit a single-centre experience of transcervical resection of the endometrium for abnormal uterine bleeding, and the short, and long-term outcomes.

Methods

107 women with AUB who were retrospectively analysed from 2008 to 2020. Ethics approval was not sought as it is a case series. All the women underwent TCRE using 26 fr resectoscope with loop electrode and roller ball cautery. They were followed up for a minimum period of 12 months to maximum of 10 years. Inclusion criteria are uterine size up to 12 weeks, and all indications of AUB. Exclusion criteria are uterus size > 12 weeks, cervical cancer or diagnosed cases of endometrial cancer. Preoperative ultrasound was performed in all women. The level of improvement following the surgery was measured using a 5-point scale. A telephone call was made to all on follow-up yearly to enquire about their menstrual symptoms. The need for a repeat hysteroscopy surgery or a hysterectomy was documented. Demographic data is presented using proportion and mean \pm SD. Tests of proportions are used to compare between the two variables. The Chi2 Pearson test was applied to compare between two variables.

Results

The mean age is 42 ± 8 years. The most common pathology was endometrial polyps ($n=36$; 34.3 %). Six women who underwent hysterectomy were found to have less improvement of symptoms 6 months following TCRE (score < 4; $p=.001$). The use of monopolar energy increased the risk of hysterectomy by 7 % (R.R 0.065 \pm SD .03; 95% CI: 0.03 - 0.14) during TCRE. The mean procedure time was 31.05 ± 3.1 . We found a 2.2 % increased risk of complications with monopolar energy, one was a uterine perforation and another was fluid overload. The mean improvement in the quality of life is $3.8 \pm .6$ as measured by the 5 - point scale. None of the women required a repeat hysteroscopy.

Conclusions

TCRE requires surgical expertise and understanding of the endometrium to be achieve optimum success in women with abnormal uterine bleeding. Before decision-making, the surgeon must discuss the options of medical and conservative surgical alternatives to hysterectomy.

Hysteroscopic Approach of Adenomyosis

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Background

Adenomyosis is a chronic Gynecologic condition affecting women of reproductive age, characterized by the presence of ectopic endometrial tissue within the myometrium. It commonly presents with abnormal uterine bleeding, pelvic pain, and infertility. Intracavitary adenomyosis can adversely impact IVF outcomes.

Methods

A 43-year-old woman presented to our clinic with complaints of excessive menstrual bleeding. Transvaginal ultrasound revealed an 11 mm Type 3 submucous myoma located on the posterior right lateral wall of the uterus. Her medical history included a laparotomic myomectomy and hysteroscopic polypectomy in 2022. The patient, who has no prior pregnancies and a strong desire for fertility, was being evaluated for embryo transfer within an IVF protocol. Due to her ongoing complaints, hysteroscopic evaluation was performed prior to embryo transfer.

Results

Hysteroscopy revealed a 0.5 cm polyp in the right cornual region, which was excised. The uterine fundus subseptum was observed. Incision was made to the lateral walls due to dysmorphic cavity with bipolar energy. During the procedure, a yellow, heterogeneous area was observed on the right lateral wall, suggestive of adenomyosis. Upon bipolar cautery contact, a substance consistent with adenomyosis was discharged. A 1 cm lesion compatible with adenomyoma was excised and its base cauterized for hemostasis. Histopathology confirmed adenomyosis.

Conclusions

Hysteroscopy offers direct, real-time visualization and the opportunity for targeted biopsies and treatment. While not a first-line treatment for adenomyosis, hysteroscopy may be beneficial in select cases of superficial focal or cystic lesions, particularly those under 1.5 cm. Techniques such as enucleation, coagulation, and cyst evacuation have been described. Further studies are needed to define the precise role of hysteroscopy in the surgical management of adenomyosis.

<https://player.vimeo.com/video/1085358872?autoplay=1>

Automated classification of endometrial pathologies from hysteroscopic images using deep learning.

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Background

Our objective was to create a deep learning model to distinguish endometrial pathologies based on hysteroscopic images.

Methods

164 hysteroscopic cases included with indication of submucosal fibroids and endometrial polyps. Initially, 380 images were included and more specifically, 45 of submucosal fibroids and 335 of endometrial polyps. All images were annotated based on histopathological confirmation. To address class imbalance, data augmentation techniques were applied, resulting in an expanded dataset of 800 images: 225 leiomyomas and 575 polyps. A Convolutional Neural Network (CNN) was developed based on pretrained VGG16 model. The CNN was trained on 80% of the data and tested on the remaining 20% to evaluate performance.

Results

CNN achieved an overall accuracy of 68.1% on test set. Accuracy, in this context, refers to the proportion of correct predictions made by the model out of the total number of predictions.

Conclusions

Results showed that CNN can distinguish endometrial pathology with moderate accuracy. Using larger, more diverse datasets could improve model's performance and make it more suitable for clinical implementation. Once optimized, such models could serve as valuable tools for both clinical practice and training.

See-and-treat hysteroscopy in diagnosing endometrial cancer

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Background

Women under suspicion for endometrial cancer may face multiple hospital visits, particularly when a polyp is suspected. To address this, we implemented a 'see-and-treat' hysteroscopic approach, enabling diagnosis and treatment during a single visit. This study evaluates its impact on diagnostic timelines, number of hospital visits, pain levels, and histological outcomes.

Methods

This study included women referred to Viborg Regional Hospital with suspected endometrial cancer between 1 May 2022 and 1 May 2023. Patients with prior histological samples or non-cancer-related referrals were excluded. Data were extracted from clinical and pathology reports.

All patients underwent transvaginal ultrasonography, followed by saline sonohysterography and cervical assessment if indicated. During the pre-implementation period (1 May – 31 October 2022), blind endometrial sampling was performed for histological evaluation, with follow-up office hysteroscopy in cases of suspected intracavitary pathology, such as polyps.

From 1 November 2022, the "see-and-treat" protocol was introduced, enabling same-session diagnostic hysteroscopy with biopsy or hysteroscopic polyp excision when indicated.

All women who underwent endometrial sampling, biopsy, or polyp excision were asked to rate their pain before, during, and after the procedure using a visual analogue scale.

Results

A total of 294 women were analysed (133 pre- and 161 post-implementation). Baseline characteristics—including age, parity, estradiol therapy, menopausal status, and comorbidities—were comparable between groups, minimising the risk of confounding. Endometrial sampling, biopsy, or polyp excision was indicated in 53% of cases.

The proportion of single-visit consultations increased from 66% to 92% (RR 2.76, 95% CI: 1.7–4.5) following implementation of the "see-and-treat" protocol. The median time to histological diagnosis for women requiring tissue assessment was reduced from 8 to 5 days ($p = 0.0007$).

Hysteroscopic procedures and endometrial sampling revealed no significant differences in cancer incidence (RR = 0.8, 95% CI: 0.3–1.9) or in reported pain levels before, during, and after the procedure ($p = 0.7$, $p = 0.4$, $p = 0.82$). The rate of inconclusive samples was lower with hysteroscopy (1%) compared to endometrial suction sampling (13%) (RR 0.1, 95% CI: 0.01–0.6).

Conclusions

The "see-and-treat" hysteroscopy approach for suspected endometrial cancer is feasible, reduces the number of clinic visits, and shortens the time to histological diagnosis for women requiring further

assessment. Hysteroscopic procedures and endometrial sampling demonstrated no significant differences in pain levels or cancer incidence.

Retroperitoneal vs. Conventional Approaches in Total Laparoscopic Hysterectomy for Benign Indications: A Tertiary Center Experience with Residents as Primary Surgeons

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Background

Advances in endoscopic surgery have established total laparoscopic hysterectomy (TLH) as a preferred alternative to abdominal hysterectomy. TLH reduces blood loss, shortens hospital stays, and lowers infection and ileus rates. Additionally, patients avoid a painful abdominal incision and experience faster recovery. The conventional TLH technique involves intrafascial dissection with uterine vessels transected close to the uterus, medial to the ureter, using a uterine manipulator. The retroperitoneal approach provides enhanced visualization of the ureters and vascular structures. This study compares perioperative outcomes of retroperitoneal and conventional TLH for benign conditions, all performed primarily by gynecology residents.

Methods

Patients who underwent TLH for benign indications within the past three years and had complete medical records were retrospectively reviewed. The cases were divided into two groups based on surgical technique: the retroperitoneal approach (n=98), the conventional approach (n=102). A retroperitoneal TLH was performed using the anterior approach. The peritoneum was opened along the round ligament to access the retroperitoneal space. After identifying the obliterated umbilical artery and the ureter at the pelvic brim, dissection proceeded lateral to the ureter to expose the internal iliac artery. The uterine artery was skeletonized where it crosses over the ureter and was coagulated at its origin. In the conventional TLH group, hysterectomy was performed without opening the retroperitoneal space, uterine artery was ligated alongside the uterine cervix. In all cases, the primary surgeon was a gynecology resident with three years of training, and the assistant surgeon was an experienced specialist.

Demographic characteristics, operative time, estimated blood loss, perioperative outcomes were collected and compared between the groups.

Results

Of the 200 patients, the median age was 45 years (41–72), and the median BMI was 24.83 kg/m² (18.7–39.6). TLH was performed in 148 patients (72%) for fibroids or adenomyosis, 32 patients (16%) for endometriosis, 13 patients (6.5%) for adnexal masses, and 7 patients (3.5%) for abnormal uterine bleeding. Operative time was similar between groups (p=0.564). In conventional group, ureteral injury occurred in 2% of cases and bladder injury in 3%, whereas no ureteral or bladder injuries were observed in the retroperitoneal approach. The rate of urinary tract injuries was significantly lower in retroperitoneal approach (p=0.041). Median haemoglobin change was 1.8 g/dL (0.2-2.4) in conventional group and 1.4 g/dL (0-1.9) mg/dL in the retroperitoneal group (p=0.886).

Conclusions

Although the retroperitoneal approach requires advanced anatomical knowledge and surgical expertise, it is a feasible method for benign Gynecological procedures, offering advantages such as improved visualization of the ureters and vascular structures, reduced risk of ureteral injury and intraoperative blood loss, and increased safety for patients with distorted anatomy. In the presence of experienced specialists with strong surgical skills, residents can successfully perform retroperitoneal interventions under proper supervision.

Implementation of Trans-Diaframatic Video-Assisted Thoracic Surgery in Selected Advanced Ovarian Cancer Cases

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Background

In patients with advanced stage ovarian cancer, if there is a suspicious lesion in the mediastinum or especially in the presence of medium to large pleural effusion, Video-Assisted Thoracoscopic Surgery (VATS) method is used. In some selected cases, as in this case, to evaluate its usefulness in determining the spread of intrathoracic disease during surgery, its potential to influence treatment decisions and its role in optimizing surgical debulking or neoadjuvant chemotherapy options, it is to show that VATS can be performed by a Gynecological Oncology surgeon through an abdominal incision that has already been opened for massive mass excision.

Methods

In this study, trans-diaphragmatic VATS was used to evaluate the presence of macroscopic intrathoracic disease. The findings obtained played an important role in staging the disease. Trans-diaphragmatic VATS has been shown to be used safely and effectively for diagnostic and therapeutic purposes such as pleural effusion drainage, pleural biopsy, and resection of thoracic tumors when necessary.

Results

In this case, the left pleural space was entered using a ten-gauge trocar using the transdiaphragmatic method. Pleural fluid sampling was taken from the left thoracic space entered with the help of a camera. As a result of macroscopic examination, no tumoral implant was observed in the thoracic cavity except on the left diaphragm. The tumor implant on the diaphragm was resected and the diaphragm was primarily repaired.

Conclusions

In this case, while open surgery is performed from the abdomen, VATS from the diaphragm can be performed by Gynecologic Oncology specialists. Staging the disease, deciding for primary cytoreductive surgery, is a valuable procedure to accurately assess the extent of intrathoracic disease in patients with advanced stage ovarian cancer and pleural effusion, to guide treatment decisions, and to optimize the choice between surgical resection or neoadjuvant chemotherapy.

<https://player.vimeo.com/video/1085505187?autoplay=1>

Assessment of a novel low cost abdominal box simulator for layers of anterior abdominal wall anatomy teaching for medical students

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Background

Understanding the layers of the anterior abdominal wall can be challenging, but clinically very important. Our aim was to create a low-cost abdominal box simulator and assess its usefulness as an adjuvant in teaching the anterior abdominal wall anatomy.

Methods

A low-cost abdominal box simulator was created using a metal box skeleton. This was covered in a layer of cling-film simulating the peritoneum. A posterior rectus sheath was created on either side using a white cotton sheet whilst thick red woollen socks were used to simulate the rectus abdominus muscles. The entire surface was then wrapped in a thick canvas to simulate the anterior rectus sheath. Finally, a commercial skin with subcutaneous tissue was affixed and the umbilicus demarcated using a pen. This simulator was used by 14 medical students (Year 1- 4) attending an introduction to laparoscopy course who were asked to provide feedback on the simulator for visiport entry for commonly used incisions.

A pre course survey was collected regarding the understanding of anterior abdominal wall anatomy and was compared with post-course feedback.

Results

Prior to attending the course, there was no student that felt completely confident about their understanding of the layers of the anterior abdominal wall and only 2 students (14%) felt confident. After the use of the simulator for teaching the layers of the anterior abdominal wall, 5 (33%) students felt very confident and 7 (50%) confident.

11(79%), 14 (100%), 10 (71%), 12 (86%), 10 (71%), 10(71%) found the simulator to be effective in understanding the layers to go through in transverse, vertical midline, Pfannenstiel, laparoscopy-first port, grid iron for appendicectomy and subcostal incisions respectively.

Feedback highlighted that using the simulator medical students were able to see all layers of the abdomen and gain excellent haptic feedback. The model was described as realistic as the students were able to identify each layer of the abdomen as they performed visiport entry and common incisions.

Conclusions

A low-cost abdominal box simulator can easily be reproduced using our technique and used as an adjuvant to teach anterior abdominal wall layers to medical students effectively.

Hospital at home in Gynaecology – Use of Virtual Ward

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Background

Virtual ward, also referred to as ‘hospital at home,’ is a model that facilitates patients receiving hospital level care at home. Digital technology such as apps and wearables enables healthcare professionals to monitor patients remotely. Alongside improving patient satisfaction through care in a familiar environment, this model also helps in optimizing the available resources in a hospital setting by reducing bed days.

The objective of this study was to assess the effectiveness and bed days saved by use of virtual ward in gynaecology in the NHS. We hypothesized that the virtual ward model will be cost and resource efficient by saving a substantial number of bed days in the department of gynaecology. Alongside this data, we also analysed the patient satisfaction.

Methods

Patients admitted in the virtual ward from March 2023 to March 2025 were reviewed from virtual ward database of the Norwich and Norfolk University NHS Hospital. Indication for admissions, the length of stay in the virtual ward the bed days saved was analysed. Patient satisfaction data was collected upon discharge.

Results

Between March 2023 and March 2025, 110 patients were admitted in virtual ward. The total number of days patients stayed in the virtual ward for all indications cumulatively was 623. Commonest indications were awaiting diagnostic imaging, hyperemesis, and day case hysterectomy. Hysterectomy and hyperemesis patients would have been discharged earlier in a hospital setting compared to their length of stay in the virtual ward. Therefore, the total number of bed days saved was adjusted to 377 days. The data over two years has demonstrated that an average of 3.5 bed days were saved per patient by the utilization of virtual ward.

98% patients reported to be very satisfied with the service with 98.6% patients happy to use the services again.

Conclusions

As predicted, the use of the virtual ward model has led to a significant number of bed days saved. Overall, it is both cost and resource efficient and has shown to have good patient satisfaction. Use of digital technology is essential for monitoring patients at home and it is important that patients are educated and are comfortable to use this technology.

Fertility Preservation in a Young Woman with Neuroblastoma: A Case Report of Ovarian Tissue Cryopreservation and Transposition

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Background

Fertility preservation is a critical component of oncologic care for young women undergoing gonadotoxic treatments such as pelvic radiotherapy. Among the available techniques, ovarian tissue cryopreservation (OTC) and ovarian transposition (OT) are recommended for patients in whom oocyte retrieval is not feasible or time is limited. According to the ESHRE guideline, OTC is particularly valuable in young women with high ovarian reserve, while OT is an established method for preserving hormonal function and minimizing the risk of premature ovarian insufficiency (POI) during pelvic irradiation.

Methods

We present a case of a 20-year-old nulligravid woman diagnosed with recurrent pelvic neuroblastoma, scheduled for sacrectomy and adjuvant pelvic radiotherapy. Prior to treatment, the patient underwent a multidisciplinary fertility preservation consultation. Surgical intervention included laparoscopic excision of one-third of the left ovarian cortex for cryopreservation using a slow-freezing protocol, followed by bilateral laparoscopic ovarian transposition. The retroperitoneal space was accessed through the pelvic brim and tunnels were created bilaterally. The infundibulopelvic ligaments were dissected, and the ovaries were mobilized by transecting the utero-ovarian ligaments and mesosalpinx. Each ovary was passed through the retroperitoneal tunnel and fixed at a location outside the radiation field, marked with metallic vascular clips for radiotherapy planning. Advanced haemostatic instruments, including ultrasonic energy devices, were employed for precise dissection and hemostasis.

Results

The procedure was completed without complications. The patient resumed spontaneous menstruation following radiotherapy. No signs of POI were observed during follow-up. Baseline serum AMH level was 3.8 ng/mL and remained within normal range. The cryopreserved ovarian tissue remains in storage for potential future orthotopic transplantation. Radiotherapy planning was successfully adjusted using the metallic clip markers. The bilateral OT procedure effectively preserved ovarian endocrine function post-treatment.

Conclusions

This case illustrates the feasibility and clinical value of combining OTC and OT in young patients requiring pelvic radiotherapy. Early referral, multidisciplinary evaluation, and meticulous surgical technique are essential for optimizing fertility outcomes. As recommended by ESHRE, these techniques offer significant reproductive benefits and should be considered standard of care in eligible patients. Incorporating radiologic markers, such as metallic clips, enhances radiotherapy planning and long-term monitoring of ovarian location.

<https://player.vimeo.com/video/1090207815?autoplay=1>

Optimizing cryopreserved ovarian tissue laparoscopic reimplantation with autologous platelet-rich plasma

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Background

In recent years, the demand for fertility preservation has risen due to higher cancer survival rates and increased awareness of life quality after gonadotoxic treatments. Studies show that auto-transplantation of cryopreserved ovarian tissue can restore ovarian function in 95% of cases, with many successful births documented. The patient's age at the time of tissue preservation significantly influences fertility potential after replanting, as younger patients typically have more viable follicles. However, follicular loss from hypoxia and ischemia-reperfusion injury remains a challenge, highlighting the need for improved transplant techniques and a deeper understanding of these mechanisms. Platelet-rich plasma (PRP), widely used in other medical fields, has shown promising results in gynecology as well.

Methods

A narrated video footage illustrating the steps of a laparoscopic technique from a single-center, prospective observational cohort study.

Results

we illustrate our experience in the management of patients with a high risk of premature ovarian insufficiency (POI) due to gonadotoxic treatments; specifically, we present the clinical case of a 38-year-old patient previously affected by Hodgkin lymphoma who underwent laparoscopy for ovarian tissue transplantation (OTT) after OTC. First, a diagnostic exploration of the pelvis and the upper abdomen was performed. After exposing the ovary, an incision at the tubal pole was made using scissors to create a small cavity. Two further 1cm peritoneal pockets were create on both sides of the pelvis, one per side after transperitoneal identification of the ureters and external iliac vessels. Samples of thawed ovarian tissue were inserted in the abdominal cavity inside an endoscopic bag with a jelled solution of autologous PRP to reduce potentially traumatism and subsequently placed into the ovaries and into the peritoneal pockets. Both the ovaries and the

peritoneal pockets were then sutured. The intraoperative and postoperative periods were uneventful. The patient was discharged one day after surgery. The transplanted ovarian tissue induced normalization of gonadotropin levels and allowed the resumption of the menstrual cycle at two- and three-months post-procedure, respectively, thus avoiding the need for hormonal replacement therapy. Follow-up transvaginal ultrasounds confirmed the presence of growing follicles at the graft sites. She is currently seeking pregnancy.

Conclusions

In conclusion, ovarian tissue transplantation with autologous PRP proves to be safe and feasible for the resumption of ovarian endocrine function. PRP enrichment may increase the survival rate of follicles after replanting cryopreserved ovarian tissue, reduce trauma during tissue mobilization, and ultimately improve the quality of the transplanted ovarian samples.

<https://player.vimeo.com/video/1085865804?autoplay=1>

Fertility-sparing surgery in endometriomas: recurrence and ovarian reserve outcomes of plasma energy ablation vs cystectomy

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Background

Cystectomy (CC) is currently considered the gold standard for endometrioma treatment. However, it may significantly reduce ovarian reserve. Plasma energy ablation (PEA) offers a tissue-sparing alternative, potentially providing better preservation of ovarian function; however, concerns remain regarding higher recurrence rates due to incomplete excision.

Methods

This retrospective cohort study included 176 women aged 18–40 with unilateral endometriomas who underwent laparoscopic PEA (n=87) or CC (n=89) between 2010 and 2023 at a tertiary center. Exclusion criteria included bilateral endometriomas, history of adnexal surgery, diminished ovarian reserve, polycystic ovarian syndrome, untreated endocrinological disorders, and concomitant hysterectomy performed during surgery. The primary outcome was the sonographically assessed recurrence of ipsilateral endometrioma (in the operated ovary) over a 48-month follow-up period. Secondary outcomes were the postoperative changes in anti-Müllerian hormone (AMH) and antral follicle count (AFC), defined as the difference between preoperative values and those assessed 6-12 months after surgery.

Results

Ipsilateral recurrence rates based on Kaplan-Meier estimates at 12, 24, 36, and 48 months were 4.7%, 15.9%, 21.5%, and 23.7% in the PEA group, and 5.7%, 11.5%, 17.0%, and 26.6% in the CC group, respectively. No significant difference in recurrence-free survival was observed between the groups (log-rank $p=0.866$). Cox regression analysis confirmed that the type of surgical technique (PEA vs CC) was not independently associated with recurrence risk after adjusting for age, body mass index, preoperative endometrioma size, total preoperative AFC, and the presence of concomitant deep infiltrating endometriosis. Similar rates of contralateral ovarian endometrioma recurrence were observed, with 48-month values of 21.5% in the PEA group and 21.4% in the CC group.

The mean postoperative variation in serum AMH was significantly lower in the PEA group (-0.3 ± 0.5 ng/mL) compared to the CC group (-0.9 ± 0.7 ng/mL), with a between-group difference of 0.6 ng/mL (95% CI: 0.32–0.87). Postoperative AFC in the operated ovary improved in the PEA group ($+2.0 \pm 3.3$), while it declined in the CC group (-1.0 ± 2.8), resulting in a significant difference of 3.0 follicles (95% CI: 2.1–3.9). Total AFC increased postoperatively in the PEA group ($+1.9 \pm 5.0$), whereas it decreased in the CC group (-1.2 ± 3.4), resulting in a statistically significant between-group difference of 3.1 (95% CI: 1.8–4.4). Following surgery, the disparity in AFC between the operated and non-operated ovaries was significantly more pronounced in the CC group (-4.0 ± 2.2) compared to the PEA group (-0.9 ± 2.4), with a between-group difference of 3.2 (95% CI: 2.5–3.9). Complete absence of antral follicles in the operated ovary was significantly more frequent in the CC group (28.1%) compared to the PEA group (6.9%) ($p=0.0002$).

Conclusions

PEA and CC demonstrated comparable ipsilateral recurrence rates over a 48-month follow-up. However, PEA was associated with significantly better preservation of ovarian reserve.

Results of Conservative and Ultra-Conservative Minimally Invasive Surgery for Borderline Ovarian Tumors in Women of Reproductive Age

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Background

Borderline ovarian tumors (BOT) are tumors characterized by mild to moderate nuclear atypia and epithelial proliferation without destructive stromal invasion, except for microinvasion, and without infiltrative growth. The most common histotypes of BOT are serous (53%) and mucinous (43%) variants. BOTs are morphologically similar to ovarian adenocarcinoma. However, the key difference between these conditions is the absence of stromal invasion in BOT, except in cases of microinvasion. This feature of the disease course allows for minimally invasive conservative surgery (conservative surgery) or ultra-conservative surgery (cystectomy or resection of one or both ovaries within healthy tissue) with staging, aimed at preserving fertility and hormonal status in patients. Research Objective: To improve surgical outcomes for BOT and to determine the optimal timing for reproductive function realization within the "recurrence-free window" after conservative and ultra-conservative minimally invasive surgical methods.

Methods

The study included 45 women of reproductive age according to the World Health Organization (WHO) criteria with a verified diagnosis of serous and mucinous borderline ovarian tumors from 2018 to 2025. Of these, 33 patients (73.3%) underwent conservative treatment. Twelve patients (26.7%) received ultra-conservative treatment. All patients underwent minimally invasive laparoscopic access. Recurrence rates were evaluated using instrumental diagnostic methods: pelvic ultrasound and pelvic MRI with contrast; blood tumor markers including CA125, HE4, ROMA index/CA 19-9, carcinoembryonic antigen (CEA). The timing for reproductive function realization within the "recurrence-free window" was assessed through pelvic ultrasound confirming an intrauterine pregnancy and blood Human Chorionic Gonadotropin (b-HCG) levels.

Results

Conservative surgical treatment was performed in 33 patients, while 12 patients received ultra-conservative treatment. No recurrences have been detected to date in 30 patients (66.7%), among whom 24 (80%) underwent conservative surgery, and 6 (20%) underwent ultra-conservative surgery. Recurrence was observed in 15 patients (33.3%). After conservative treatment, 6 patients (40%) experienced recurrence, with an average time to recurrence of 32 months (7;72). After ultra-conservative treatment, 9 patients (60%) experienced recurrence, with an average time to recurrence of 19 months (6;36). Pregnancy was planned by 33 patients (73.3%). Pregnancy occurred spontaneously in 13 patients (39.4%), after conservative treatment in 5 patients (38.5%), with an average time to conception of 53 months (38;72). After ultra-conservative treatment,

pregnancy occurred in 8 patients (61.5%), with an average time to conception of 34 months (24;52). Pregnancy did not occur in 20 patients (60.6%) who planned pregnancy. Menstrual function remained unchanged after all surgical interventions.

Conclusions

The conducted study demonstrates the effectiveness of conservative and ultra-conservative minimally invasive methods in treating BOT in women of reproductive age for preserving fertility and maintaining hormonal status. Ultra-conservative approaches enable reproductive function realization but require strict dynamic monitoring due to a high risk of recurrence. Determining the optimal timing for reproductive function realization is possible immediately after surgery

Fertility-sparing management in early-Stage endometrial cancer: A case-based approach

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Background

Endometrial cancer is the 6th most common cancer in women. While primarily affecting post-menopausal women, can be a devastating diagnosis for pre-menopausal women who have not completed -or began- childbearing. However, younger women tend to be diagnosed with well-differentiated endometrioid adenocarcinoma and at early stages. Thus, fertility-sparing management has become an option, with a growing body of evidence showcasing its efficiency and safety in selected patients. This video outlines a fertility- preserving management strategy for a 28-year-old nulliparous woman diagnosed with endometrioid adenocarcinoma.

Methods

The patient presented with abnormal uterine bleeding (AUB). Endometrial biopsies confirmed grade 1 endometrioid adenocarcinoma. Pelvis MRI demonstrated no myometrial invasion, staging her as IA. The patient expressed the wish to preserve fertility. A thorough history, workup and clinical examination deemed the patient suitable and, after consultation with gynae-oncology and fertility specialists, a fertility-sparing treatment was decided and oral progestin was commenced. The protocol involved hysteroscopic evaluation of the endometrial cavity, resection of the tumor and a portion of the underlying myometrium using bipolar diathermy (loop), as well as biopsies of the remaining endometrium. Consequently, a levonorgestrel-releasing intrauterine device (LNG-IUD) for local progestin delivery was inserted and systemic hormonal therapy with oral megestrol acetate was continued at a dosage of 160mg daily.

Results

At 3 months, a hysteroscopy was performed. Biopsies revealed histologic regression, showing complete response. The patient is currently under surveillance, with follow-up endometrial biopsies scheduled after 6 months of conservative management to assess the treatment's success.

Conclusions

This case demonstrates the efficiency of fertility-preserving management in carefully selected patients, further underscoring the value of additional hormonal treatment in achieving regression.

<https://player.vimeo.com/video/1085792206?autoplay=1>

Laparoscopic bilateral ovarian transposition in a patient with cervical cancer – Video Abstract

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Background

In young female patients diagnosed with cervical cancer, ovarian transposition is performed to prevent gonadal failure following pelvic radiotherapy. Laparoscopic bilateral ovarian transposition aims to preserve fertility and hormonal function by relocating both ovaries outside the radiation field through a minimally invasive approach.

Methods

The video demonstrates a bilateral laparoscopic ovarian transposition procedure performed on a 26-year-old patient diagnosed with cervical cancer. Pelvic anatomical structures were systematically evaluated, and bilateral ovarian mobilization was planned. Careful dissection of the ligaments was performed to preserve the ovarian vascular pedicles. Once adequate mobilization was achieved, the ovaries were directed laterally, beyond the iliac vessels, and positioned near the paracolic gutters. Each ovary was anchored to the lateral pelvic wall using interrupted sutures. The surgical field was irrigated and re-inspected prior to completion of the procedure, which was finalized without complications. Metallic clips were applied to the ovarian tissue to facilitate localization during radiotherapy.

Results

The procedure was completed without any intraoperative complications. Postoperative imaging confirmed the preservation of ovarian vascularization and appropriate positioning.

Conclusions

This procedure is a safe and effective method for preserving fertility and endocrine function in young women diagnosed with cervical cancer. The minimally invasive approach offers advantages such as reduced morbidity, shorter hospital stays, and faster postoperative recovery. Optimal patient selection, surgical familiarity with pelvic anatomy, and meticulous dissection technique are essential for procedural success. Laparoscopic transposition, when performed prior to pelvic radiotherapy, allows for the potential of spontaneous ovulation and future assisted reproductive options.

<https://player.vimeo.com/video/1085500428?autoplay=1>

Comparison of Laparoscopy and Laparotomy in Terms of Recurrence in Borderline Ovarian Tumors

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Background

The aim of this study was to compare the recurrence rates of borderline ovarian tumors underwent laparoscopy and laparotomy.

Methods

The data of the study were obtained from the database of Mersin University Hospital Gynecological Oncology Clinic. Patient demographics, surgical method, histological evaluation, tumor stage, and recurrence data were collected from the hospital database.

Results

A total of 70 cases with stage 1 and borderline final pathology were included in the study. Of the 70 cases, 11 (15.7%) were undergone laparoscopic surgery and 59 (84.2%) were undergone laparotomy. Fertility-sparing surgery (FSS) was performed in 5 of 11 cases (45.4%) that underwent laparoscopy and in 28 of 59 cases (47.4%) that underwent laparotomy. The number of recurrences was determined as three in 70 cases (4.28%). Recurrence was observed in one of 11 cases (9.09%) that underwent laparoscopy, and two of 59 cases (3.38%) that underwent laparotomy. All three cases with recurrence were undergone unilateral cystectomy with the aim of fertility-preserving surgery and all recurrences were observed in the ovary which cystectomy was performed. The histological subtypes of these three cases were serous, mucinous and seromucous.

Conclusions

In conclusion; in borderline ovarian tumors, it seems that caution should be exercised in terms of recurrence, especially if a fertility-preserving approach is planned. In our study, laparotomy seems to be superior to laparoscopy in terms of recurrence if FSS is planned in patients with borderline ovarian tumor.

Improvements in Robotic Colposacropexy with the Da Vinci XI System: The Italian Experience

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Background

The introduction of robotic surgery with the Da Vinci XI system represents a significant advancement in minimally invasive Gynecological procedures. This study aims to evaluate the improvements offered by robotic Colposacropexy using the Da Vinci XI system, compared to conventional laparoscopic Colposacropexy, even when performed by surgeons highly experienced in laparoscopy.

Methods

This retrospective study analyses patients who underwent Colposacropexy at Sant 'Eugenio Hospital before and after the introduction of the Da Vinci XI system. Patients were divided into two groups: - Group 1: 120 patients treated with laparoscopy between 2018 and 2022 - Group 2: 100 patients treated with robotic surgery between 2023 and 2024. All types of pelvic organ prolapse were included. Procedures in both groups were performed by the same surgeons, who were previously experienced in laparoscopy and subsequently completed advanced training in robotic surgery. All patients were evaluated at a 4-month follow-up. To reduce operative costs, three robotic arms were used instead of four in 50% of the robotic cases. The surgical procedure involved subtotal hysterectomy with bilateral salpingo-oophorectomy and Colposacropexy using a titanized mesh for both anterior and posterior compartments.

Results

No intraoperative complications or conversions to open surgery occurred in either group. Postoperative recovery was comparable, with all patients discharged on postoperative day 2, and no significant difference in postoperative analgesic use. The mean operative time was significantly reduced in the robotic group (81 minutes) compared to the laparoscopic group (153 minutes). This time reduction contributed to increased surgical throughput and better utilization of operating room resources. No cases of prolapse recurrence were observed during the 4-month follow-up in either group.

Conclusions

In our experience, robotic Colposacropexy using the Da Vinci XI system significantly reduces operative time without compromising clinical outcomes. The enhanced precision and 3D visualization offered by the robotic platform increase surgical confidence, even among highly skilled laparoscopic surgeons. These advantages may contribute to reducing surgical waiting lists in Italian public hospitals for pelvic organ prolapse procedures.

Autotransplantation of Cryopreserved Ovarian Tissue - How it's done and Clinical Results

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Background

Fertility protection in cancer patients is regarded as increasingly important. The German, Austrian and Swiss network Fertiprotekt, founded in 2006, is a collaboration of 158 fertility centres and institutions to provide such services and collect data for enhancing quality and clinical results. In 2009 UniKid at Düsseldorf University Hospital, as one of the founding members, could report on the first baby born in Germany after fertility protection. We want to share our experience with cryopreservation and auto implantation of ovarian tissue, provide footage of the laparoscopic procedure and clinical data on outcome as an institution, where all steps from collecting tissue until delivery can be performed at one single location.

Methods

As one of the methods of fertility preservation we describe the collection of ovarian tissue, processing, cryopreservation, storage, and thawing, including a vitality analysis. An emphasis of the video is laid on the surgical reimplantation of the tissue. Clinical data of 893 patients with cryopreserved tissue and 51 patients with 60 transplantations in Düsseldorf were collected and processed.

Results

The Düsseldorf center contributes almost 40% to the total number of cryopreservations and transplantations of the network Fertiprotekt. The success rates per transplantation (n=60) are: 28 pregnancies (46.7%), 19 livebirths (31.7%) and 4 ongoing pregnancies (6.7%). The success rates per patient (n=51) are: 20 for pregnancies (39.2%) and 14 for livebirths (27.5%). 12 women conceived spontaneously whereas 8 women underwent ART (assisted reproductive technology) treatment

Conclusions

Cryopreservation and Autotransplantation of ovarian tissue are a feasible and even more successful method to preserve fertility in female cancer patients. Its main advantage is the short time between cancer diagnosis and collection of the tissue for preservation which keeps the chance of an early start of cancer treatment. Among the biggest challenges is a demanding infrastructure for the processing of the tissue. The possibility of providing every step in one single center is an asset.

<https://player.vimeo.com/video/1083093023?autoplay=1>

robotic burch colposuspension with da vinci single port system

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Background

The gold standard for treatment of stress urinary incontinence (SUI) is the midurethral slings. However, due to potential complications and inconstant long-term efficacy, alternative surgical strategies continue to be explored. Burch colposuspension may gain renewed relevance with the advent of advanced surgical technologies such as the Da Vinci® Single Port (SP) robotic system. We present a case of SUI correction using a robotic Burch colposuspension approach performed via the Da Vinci® SP platform.

Methods

A 47-year-old female patient (BMI: 22.43) with a history of two uncomplicated vaginal deliveries presented with recurrent SUI. Her previous treatment with a single-incision sling had failed and was complicated by bladder injury (cystotomy), leading to the partial removal of the device. The pre-treatment ICIQ-SF (international consultation on incontinence questionnaire) score was 17.

Patient was in lithotomy position and 10° Trendelenburg.

A single 27 mm incision was performed 8 cm above pubis.

Bilateral Burch colposuspension was achieved using non-absorbable Ethibond® 2-0 sutures, anchoring the anterior vaginal wall—and therefore the proximal urethra and bladder neck—to the ipsilateral Cooper's ligaments

Results

The procedure was completed without intraoperative or postoperative complications with negligible blood loss. The patient was discharged on postoperative day one. At pre-discharge evaluation, ultrasound revealed no urethral hypermobility, and a stress test showed no urinary leakage. After 1 month the iciq-sf score was 0 with a PGI-I (patient global impression of improvement) score of 0 (very improved)

Conclusions

Robotic Burch colposuspension using the single port technique proved to be technically feasible and safe in this preliminary case. This approach may represent a valid surgical option for patients with SUI. Further studies with larger cohorts and long-term follow-up are needed to assess clinical efficacy.

<https://player.vimeo.com/video/109022247?autoplay=1>

When planes deceive: Mastering bladder mobilization in complex laparoscopic cases

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Background

Injury to the urinary tract is a known risk in any Gynecologic surgery due to distorted anatomy from conditions like adhesions or endometriosis. While laparoscopic hysterectomy offers many patient benefits, a challenging bladder dissection can quickly become a critical point in the procedure.

This video aims to demonstrate techniques for managing difficult bladder dissections across three illustrative laparoscopic hysterectomy cases.

Methods

We aim to present a compilation of surgical videos which demonstrate several strategies for challenging bladder dissections during laparoscopic hysterectomy. Informed consent was taken before the surgery from each patient regarding use of surgical video for scientific purposes without disclosing any personal details.

Results

Several effective techniques were identified for managing challenging bladder dissections during laparoscopic hysterectomy. These included utilizing bladder backfilling to clearly delineate its boundaries and minimize injury risk, employing an initial lateral approach to establish a safe surgical plane for adhesiolysis, and initiating a posterior colpotomy on unscarred tissue planes before extending the incision cranially to centralize the adhesion away from healthy tissue. These tailored approaches facilitate a safer and more precise dissection in difficult surgical scenarios.

Conclusions

Ultimately, ensuring a successful bladder dissection comes down to the surgeon's constant vigilance: always identifying and respecting anatomical landmarks, and applying a patient, meticulous technique throughout the entire procedure. This careful approach is fundamental to achieving success.

<https://player.vimeo.com/video/1090203822?autoplay=1>

Management of severe mesh-related complications following sacrocolpopexy

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Background

Sacrocolpopexy (SCP) with synthetic mesh is the gold-standard surgical approach for pelvic organ prolapse (POP) but can lead to complications such as mesh erosion, chronic pelvic pain, and infection. Early diagnosis and appropriate surgical management are critical in complex cases.

Methods

This video shows the case of a 43-year-old woman who presented with chronic abdominal and lower back pain radiating to both lower limbs shortly after undergoing SCP for POP. Initial conservative treatment failed. A diagnostic laparoscopy was performed with intent to remove the SCP mesh but only partial excision was achieved due to dense adhesions.

At our center, the patient underwent robotically-assisted laparoscopic complete mesh excision using the Da Vinci Xi system, with concurrent placement of a single-incision mid-urethral sling (Altis® system) for SUI. The procedure was performed with multidisciplinary coordination between gynecology and urology and involved meticulous dissection around a gossypiboma-like inflammatory mass adjacent to the right ureter. The right ureter was individualized and isolated using a surgical vessel loop. The mass was dissected all along the ureter until complete resection. Attention was then directed to the vaginal mesh. Dissection was carried out until complete excision of the eroded vaginal mesh was achieved, ensuring the removal extended to healthy, well-vascularized tissue suitable for closure. The vaginal defect was closed using a continuous, barbed suture (V-LOC™).

Results

The patient reported complete resolution of her chronic abdominal and lower back pain, as well as full recovery from SUI.

Conclusions

Complete robotic mesh excision was effective in resolving the patient's symptoms and pelvic floor dysfunction. This case highlights the complexity of managing delayed SCP mesh complications and the importance of individualized, multidisciplinary management. Robotic surgery offers significant advantages in the safe resection of mesh embedded in critical anatomical regions, especially in reoperative and fibrotic fields.

<https://player.vimeo.com/video/1087977899?autoplay=1>

Uterine-Sparing Modified Laparoscopic Lateral Suspension

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Background

We present a short video case study of laparoscopic lateral suspension surgery to spare the uterus in a patient with symptomatic pelvic organ prolapse by two clinical residents under the supervision of a specialist. The patient, a 45-year-old woman with a history of three vaginal deliveries, presented with a prolapsed vaginal lesion. Her medical history was unremarkable except for hypertension and a previous right ovarian cystectomy. Gynaecological examination revealed grade 3 uterine descent. Cystocele and rectocele were absent. Following evaluation, we decided to perform uterus-sparing laparoscopic lateral suspension.

Methods

This video demonstrates a modified laparoscopic lateral suspension technique. We placed a 10 mm camera trocar at umbilical level and two 5 mm trocars bilaterally, 2.5 cm above the anterior iliac crest. The vesicovaginal space was then dissected to the lowest possible level. Two bites were then taken from the cervix using a 48 mm Mersilene needle and tape suture. A retroperitoneal canal was then created using 5 mm trocar incisions to suspend the ligamentum rotundum. The uterus was then suspended by passing the Mersilene tape suture ends through the tunnel without tying any knots. Finally, the peritoneum was closed with an absorbable suture. There were no intraoperative or postoperative complications.

Results

Unlike traditional methods, the use of Mersilene Tape Suture significantly reduces the risk of mesh complications. In addition, Mersilene suture is cheaper and easier to use than mesh. Furthermore, since 5 mm trocar incisions are used, there is no need for additional incisions. This technique differs from the traditional lateral suspension method in that it is shorter, more minimally invasive, and cost-effective. Compared to the Mulayim technique described in the literature, it involves fewer incisions.

Conclusions

Modified laparoscopic lateral suspension is a surgical technique that has recently become more popular for treating POP. However, more extensive studies are needed to evaluate its effectiveness.

<https://player.vimeo.com/video/1085738389?autoplay=1>

Extraperitoneal laparoscopic colposuspension for mesh-free surgical treatment of female stress urinary incontinence

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Background

In the surgical treatment of female stress incontinence (SUI), tension-free vaginal tape (TVT) is considered the gold standard but has come under increasing criticism in recent years, possibly due to safety warnings from the FDA. Compared with intraperitoneal LSC (ILCS), extraperitoneal laparoscopic colposuspension (ELCS) is a rapid, safe, and successful surgical treatment. The aim of this abstract is to show that for the right patient population, such as those with a hypermobile urethra with possible defects in the pubourethral ligament (PUL) after vaginal delivery, reconstructive surgery by ELCS is possible and offers mesh-free treatment.

Methods

In patients with SUI, ELCS was compared with ILCS in terms of operating time, complications, and success rates in 53 patients after a mean of 22 months. For successful first-entry access to the extraperitoneum, we used an Applied medical®-11 mm visual trocar under CO₂ insufflation. The success rate was measured via the International Consultation on Incontinence Questionnaire-Urinary Incontinence Short Form (ICIQ-UI SF; 0-21 points) and the Numeric Rating Scale (NRS; 0-10 points). The Clavien–Dindo classification was used to record complications. A video of ELCS was uploaded.

Results

Fifty-three patients were enrolled in this retrospective study with ethical votum. The inclusion criterion was first- or second-degree SUI with a hypermobile urethra (HMU), measured by pelvic floor sonography (PFS). Patients with HMU had a bladder neck descent (BND) of more than 15 mm. This indicates a weakness or defect of the PUL. We treated 44 patients with ELCS with a median operation time of 52.5 minutes (Q1 45.0; Q3 67.0) and 9 patients with ILCS with a median operation time of 76 minutes (72.0;97.0). There were no differences in characteristics such as age, weight, height, or number of vaginal deliveries or caesarean sections. Complications were rare in both groups, with one chronic urinary tract infection (> 3 times/year) (Clavien–Dindo II) occurring in the ELCS group and one case of de novo urgency incontinence (Clavien–Dindo II) occurring in the ILCS group. The ICIQ-UI SF for ELCS was 15.2 points (95% CI 14.3; 16.1) before surgery and 3.4 points (1.7; 5.0) after surgery. The ICIQ-UI SF for the ILCS was 15.7 points (14.7; 16.7) before surgery and 5.4 points (0.0; 11.0) after surgery. The NRS score for ELCS was 7.7 points (7.1; 8.3) before surgery and 1.8 points (0.9; 2.7) after surgery. The NRS score for ILCS was 8.2 points (7.6; 8.9) before surgery and 2.7 points (0.1; 5.4) after surgery. The overall continence rate in both groups after 22 months was 78%.

Conclusions

ELCS offers an excellent mesh-free alternative to TVT, with an approximately 1/3 shorter operation time than ILCS does, few complications and high continence success rates.

<https://player.vimeo.com/video/1085440628?autoplay=1>

Lateral Approach in Robotic Surgery for Paravaginal Defect Associated with Colposacropexy

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Background

The aim of this study is to combine the traditional sacrocolpopexy technique with the repair of paravaginal defects to reduce the risk of prolapse recurrence and the onset of stress incontinence after surgery. A significant portion of anterior compartment prolapse is linked to lateral defects, as described in the second level of De Lancey. In these cases, the pubocervical fascia becomes detached from the arcus tendineus fascia pelvis (ATFP). Often, apical prolapse coexists with lateral defects. Lateral defects in the pubocervical fascia not only contribute to anatomical defects but also lead to functional issues, such as stress incontinence. This often leads to an increase of stress incontinence to develop after colposacropexy. Diagnosing stress incontinence in the context of multicompartmental prolapse can be challenging; however, paravaginal defects can be diagnosed preoperatively through clinical examination and instrumental methods like ultrasound and magnetic resonance imaging

Methods

From January 2022 to December 2023, we performed 43 robotic sacrocolpopexy with lateral fascia reconstruction using the Da Vinci XI system. All patients were assessed via Gynecological examination, including the pelvic organ prolapse quantification (POP-Q) system. We applied the combined surgical technique only in patients with multicompartmental prolapse. Initially, we performed subtotal hysterectomy with salpingoophorectomy. A single polypropylene titanized mesh was used, fixed anteriorly to the vesicovaginal fascia with non-absorbable sutures and posteriorly to the rectovaginal fascia, and secured to the promontory with a non-absorbable suture (Y mesh). Subsequently, with a lateral approach, we made a longitudinal incision in the peritoneum lateral to the umbilical ligament, entering the avascular space of Retzius. After the dissection, we identified the pubic symphysis anteriorly, and the ATFP and pubocervical fascia inferiorly. Two non-absorbable sutures were placed on each side, spaced 2-3 cm apart, between the pubocervical fascia, ATFP, and Cooper's ligament

Results

Robotic sacrocolpopexy combined with paravaginal defect reconstruction in patients with multicompartmental prolapse demonstrated good results in terms of recurrence rates, safety, and stress incontinence. The procedure took an average of 100 minutes to complete, with minimal blood loss and no complications. Patients were observed overnight, underwent a successful voiding trial the following morning, and were discharged two days later. One-year follow-up showed no pain, complications, or recurrences

Conclusions

Combining both procedures during surgery minimizes the risk of recurrency in patients with multicompartmental prolapse and reduces the onset of stress urinary incontinence after a single

colposacropexy. The dual technique aims to restore anatomical integrity as closely as possible, since the second De Lancey level has a horizontal axis, unlike the vertical axis of the first level. In these patients, single sacrocolpopexy may be insufficient because it does not address the defect in the lateral pubocervical fascia, which can lead to a high risk of lateral prolapse recurrence over time

challenging total hysterectomy due to a large parametrial fibroid

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Background

A 45-year-old patient with a 7 cm myoma near the cervical region underwent robotic hysterectomy with bilateral salpingectomy. we wanted to present a surgically challenging case of robotic hysterectomy complicated by the presence of a large parametrial fibroid, highlighting the anatomical distortion and technical difficulties encountered during the procedure.

Methods

our patient had a 7 cm parametrial fibroid closely attached to the right pelvic sidewall. preoperative the patient underwent a planned robotic hysterectomy.

Results

during surgery, the parametrial fibroid was found to be deeply embedded in the right parametrium, displacing the ureter laterally and obscuring key anatomical landmarks. sharp and blunt dissection was carefully performed to isolate and preserve the ureter. uterine artery ligation was achieved after meticulous mobilization. the fibroid was resected en bloc with the uterus. robotic hysterectomy was completed without intraoperative complications. postoperative course was uneventful, and the patient was discharged on postoperative day 3.

Conclusions

parametrial fibroids may pose significant surgical challenges due to altered pelvic anatomy and proximity to vital structures. detailed preoperative imaging, careful dissection, and precise surgical planning are essential to avoid complications and achieve successful outcomes.

<https://player.vimeo.com/video/1084978378?autoplay=1>

How to improve surgical results of cystocele repair?

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Background

We present a case of a 75-year-old women with a rapid prolapse recurrence following a subtotal hysterectomy, bilateral adnexectomy and promontofixation. The main objective of this video is to demonstrate a surgical approach for cystocele repair in the context of prolapse recurrence after sacrocolpopexy. Current evidence suggests that performing anterior colporrhaphy concurrently with sacrocolpopexy may reduce recurrence, as anterior compartment prolapse is a common site of failure.

Methods

We present a step-by-step educational video emphasizing cystocele repair prior to mesh placement, recorded in a university-affiliated tertiary care hospital.

Results

Under general anaesthesia, the patient was placed in lithotomy position. The procedure followed these steps:

- **Step 1: Exposure** – T-lifts were used to suspend the colon, small bowel, and bladder, ensuring clear visualization.
- **Step 2: Dissection** – The vesicovaginal space was dissected with attention to bladder margins. Methylene blue instillation aided identification.
- **Step 3: Plication** – The anterior vaginal wall was reinforced with interrupted non-absorbable sutures. A circular plication technique was chosen to avoid vaginal shortening while providing strong support. This approach may also reduce the risk of mesh exposure by adding a native tissue layer.
- **Step 4: Mesh Placement** – Anterior mesh was positioned and secured to the pre-existing sacrocolpopexy mesh.
- **Step 5: Peritonization** – Non absorbable sutures were used to peritonise the mesh and minimize exposure risk.

Conclusions

Laparoscopic sacrocolpopexy is an effective treatment for pelvic organ prolapse. Some risk factors can impact the results. Anterior vaginal vault plication prior to mesh placement may improve long term results and should be considered in recurrence cases.

<https://player.vimeo.com/video/1084306007?autoplay=1>

Novel technique of native tissue laparoscopic sacrocolpopexy using autologous rectus fascia to treat apical vaginal prolapse.

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Background

The lifetime risk of undergoing surgery for pelvic organ prolapse is 11% with a reoperation rate of 30% using traditional repair. Post hysterectomy vault prolapse has been reported to follow 11.6% of hysterectomies performed for prolapse and 1.8% for other benign diseases. Sacrocolpopexy has higher subjective satisfaction, and lower rates of reoperation and dyspareunia compared to sacrospinous ligament fixation. Concerns about the use of mesh in the pelvis have resulted in significant reduction in mesh prolapse surgery, both vaginally and abdominally, along with patient's refusal of mesh insertion. Recently, the novel laparoscopic approach to use autologous rectus fascia for stress incontinence as a mid-urethral sling has proven effective in the medium term (1). To our knowledge, the use of autologous rectus fascia laparoscopically to treat apical vaginal prolapse has not been reported before. In this video, we demonstrate the use of autologous rectus fascia, as non-mesh native tissue option, laparoscopically to restore apical support in post hysterectomy vault prolapse and in cases of uterine prolapse.

Methods

Sixty-three patients with apical prolapse underwent autologous rectus fascia laparoscopic sacrocolpopexy between January 2023 and April 2024. Preoperatively, all patients were evaluated using the Prolapse Quality of Life Questionnaire (PQOL) and Prolapse and Incontinence Sexual Function Questionnaire (Short Form) (PISQ-12). Patients were examined using the Pelvic Organ Prolapse Quantification System (POP-Q). All patients were followed up at six months and one year. At follow up, patients filled the P-QOL and the PISQ 12 questionnaires, and Patient Global Impression of Improvement (PGII) questionnaire. Patients were examined using the POP-Q system pre and post operatively. The primary outcome measure was the absence of "vaginal bulge" symptoms defined as "none" or "little" on the PQOL questionnaire.

Results

The average patient age was 60.3 years, with average BMI of 28.8. 34 patients had previous hysterectomy. The surgery was completed laparoscopically in all cases. Operative time ranged from 110 – 140 minutes. No peri operative complications were reported. At one year post operatively, patients' quality of life domains showed significant improvement apart from general health. 54 patients (85.7%) reported cure of the vaginal bulge on the P-QOL questionnaire. 56 patients (88.8%) reported feeling either "much better" or "very much better" on PGII questionnaire. Pre operative point C ranged from 0 to +4cm (Mean +1 cm). At one years, mean post-operative point C was -7.6cm (-8 to -5) ($p < 0.001$). There were no cases of new onset dyspareunia.

Conclusions

To our knowledge, this is the first description of autologous rectus fascia laparoscopic sacrocolpopexy. The procedure has comparable success to mesh sacrocolpopexy, with avoidance of

mesh complications, including pain, erosion, and dyspareunia. This is expected to increase patient acceptability and uptake of this procedure.

References:

1. Fayyad A, et al. BJOG, 2024, 131(12): 1587-1590.

<https://player.vimeo.com/video/1075120456?autoplay=1>

Mesh-less laparoscopic treatment of apical prolapse

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Background

Pelvic organ prolapse (POP) is a prevalent condition that affects a significant portion of women during their lifetimes, ranging from 8% to 40%.

Sacrocolpopexy “gold standard” for treatment of patients with apical prolapse.

The implantation of synthetic mesh was associated with complications such as perforation into the bladder, urinary tract, and bowel, resulting in infection and pain. The production of transvaginal meshes for prolapse was banned by the United States Food and Drug Administration (FDA) in April 2019, suggesting imminent restrictions against using mesh in the abdominal repair of POP. Therefore, alternative urogynecological management options are needed for such patients.

This video provides an overview of mesh-less alternatives for SCP. In our clinic, a new modified procedure of mesh-less laparoscopic sacral colpopexy (LSC) was performed, which used a non-absorbable polyester suture (Ethibond) combined with uterosacral ligament suspension.

Methods

Our patient is a 60-year-old woman and has a history of 6 spontaneous vaginal deliveries. The patient has complaints of urinary incontinence and prolapse. The patient is placed into the lithotomy position. Low abdominal pressures of 8-10 mmHg with humidified CO₂ are used to decrease the postoperative pain and to reduce peritoneal inflammation. Trocars are placed in standard positions, with one optical trocar in the umbilicus and three 5 mm trocars placed in the suprapubic area.

In our clinic, a novel adaptation of LSC has been introduced, featuring a mesh-free approach. This technique involves the use of a no. 1 nonabsorbable polyester suture (Ethibond; Ethicon, Inc, Somerville, NJ) coupled with a non-cutting taper needle, in conjunction with USLS (Uterosacral Ligament Suspension). A new modified laparoscopic meshless sacrocolpopexy was performed using nonabsorbable polyester sutures (Ethibond) with the vaginal stump suture suspended over the right sacral and sacral anterior longitudinal ligaments. This new surgical procedure not only has the advantages of the 2 classical traditional pelvic floor surgical procedures, such as sacrocolpopexy and uterosacral ligament suspension, but also has no complications related to mesh. It has a good curative effect and is easily accepted by patients. It has strong clinical applicability and promotion and is also suitable for patients with general economic conditions.

Results

At the 3 months follow up, the patient described her prolapse symptoms as 'very much better' and urinary incontinence symptoms as 'much better'.

Conclusions

The absence of mesh translates to significant cost savings, offering patients similar outcomes at a lower expense. Our enhanced technique strategically combines the superior suspension point from laparoscopic LSC with the doubly strengthened suspension of USLS, harnessing the benefits of both approaches to create a more robust suspension. However, a long-term and large sample study is required for evaluating the surgery's long-term efficacy.

<https://player.vimeo.com/video/1071495575?autoplay=1>

Transcervical Fibroid ablation in the outpatient setting: Pragmatic Observational study of 100 women

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Background

Sonata fibroid ablation uses radiofrequency energy, guided by intrauterine ultrasound, to reduce fibroid size without incisions. Our tertiary centre is the largest global centre performing Sonata predominantly in an outpatient setting under local anaesthesia. This review assesses its effectiveness, feasibility, and patient-reported outcomes.

Methods

A retrospective review was conducted of patients treated with Sonata radio frequency ablation for symptomatic fibroids between November 2021 and January 2025. Data collected included fibroid size, treatment time, intra-procedural pain scores, and patient satisfaction using the Uterine Fibroid Symptom and Health-Related Quality of Life (UFS-QOL) questionnaire.

Results

One hundred patients (mean age 44 years) underwent Sonata treatment, with 75% treated as outpatients under local anaesthesia and 25% under general anaesthesia. Of those treated in the outpatient setting, 57% used additional Entonox, with an average pain score on the visual analogue scale of 3(1-10). The mean fibroid diameter was 4.38 cm, requiring an average of 2.08 cycles per fibroid and 7 minutes 22 seconds for ablation. Post-ablation data were available for 82 patients, with UFS-QOL scores improving from 130 pre-treatment to 67 post-treatments. The overall surgical reintervention rate was 13.3%, including 9.3% who underwent hysterectomy and 1 patient underwent repeat fibroid ablation.

Conclusions

Sonata is a safe, effective, and minimally invasive treatment for fibroids with high patient acceptability. Performing the procedure in an outpatient setting improves patient choice and accessibility, mitigating the risks of general anaesthesia and prolonged hospital stays. Offering this treatment in selected women reduces the morbidity from invasive surgery like myomectomy and hysterectomy, thereby reducing inpatient waiting lists and backlog in gynaecological surgery.

Development and clinical validation of an objective assessment tool for Minimally Invasive Hysterectomy

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Background

Hysterectomy is one of most performed Gynecological procedure worldwide. Recent decades have witnessed a significant uptake of laparoscopic approaches, further enhanced by the introduction of robotic-assisted surgical techniques. While technical proficiency is increasingly recognized as being closely linked to patient outcomes in different surgical specialties, standardization of training and assessment in minimally invasive Gynecological surgery remains challenging. This study aimed to develop and validate a comprehensive assessment tool for minimally invasive hysterectomy and investigating associations between surgical performance and postoperative outcomes.

Methods

An international multi-center mixed-method study was conducted. A task analysis was developed by a steering group of seven gynecologists, followed by a Delphi consensus to identify essential procedural phases, potential technical errors, and critical safety viewpoints. The resulting assessment tool was validated using unedited minimally invasive hysterectomy videos assessed by multiple raters under a national prospective multi-centre observational cohort study. Inter-rater and intra-rater reliability were calculated using Cronbach's alpha and intraclass correlation. Concurrent validity was assessed through correlation with a validated error assessment tool (OCHRA), the modified Global Evaluative Assessment of Robotic Surgery (mGEARS), and the Global Operative Assessment of Laparoscopic Skills (GOALS), while predictive validity was established by correlating scores with clinical outcomes including operative time, blood loss, and postoperative complications according to the Clavien-Dindo classification.

Results

After a two round Delphi Consensus study amongst 17 international experts from five continents the Minimally Invasive Surgery Hysterectomy Skills (MISHYS), composed of seven phases and four quality measures, was developed, showing excellent face and content validity (CVI=0.8-1.0)

Subsequently, a total of 30 unedited robotic-assisted and laparoscopic hysterectomy videos (78 hours) were analysed for reliability and validity of the newly developed tool. The MISHYS tool demonstrated excellent inter-rater reliability (ICC=0.969, CI:0.922-0.986) and good internal consistency across all procedural phases (Cronbach's α =0.743-0.834). Significant negative correlation was observed between MISHYS scores and the validated error assessment tool (r =-0.607, p <0.001), mGEARS (r =-0.788, p <0.001) and GOALS (r =-0.508, p =0.03) confirming concurrent validity. The assessment tool also demonstrated predictive validity, with higher MISHYS scores correlating with

decreased operating time ($r=-0.397$, $p=0.049$), reduced blood loss ($r=-0.432$, $p=0.040$), and fewer postoperative complications ($r=0.345$, $p=0.045$).

Conclusions

To our knowledge, this is the first study showing direct correlation between surgical skills and patient outcomes in minimally invasive hysterectomies. With the newly developed MISHYS tool showing direct correlation between important peri-operative markers, this study shows that objective and valid evaluation of technical skills during minimally invasive gynaecological surgery is feasible. Further validation in larger cohorts will be essential to assess its application for summative assessment in training curriculums

**An intelligent transvaginal contained bulk tissue extraction system during hysterectomy –
Investigational device case report**

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Background

In minimally invasive hysterectomy of large uteruses, one of the greatest challenges is safe tissue extraction and the time this requires. Therefore, innovation in equipment that can make this possible is necessary. We present the case of a patient that underwent hysterectomy of an enlarged uterus in whom we used an intelligent transvaginal contained bulk tissue extraction system. Our objective is to demonstrate the safety and feasibility of a novel contained tissue extraction system during hysterectomy of enlarged uterus.

Methods

The Claria System is a novel, transvaginal system that can extract uterine and fibroid tissues. The system, currently under investigation for use in laparoscopic hysterectomy, consists of a multi-layer composite container paired with a 36mm diameter cylindrical blade and a console that spins the blade and enables electrical communication between both. "Auto-shutoff" technology detects when the blade contacts the metallic intermediate layer of the container which immediately stops the blade before it can breach the container and contact pelvic organs. The patient is a 49-year-old woman who underwent a total hysterectomy for an enlarged fibroid uterus with abnormal uterine bleeding with severe pain and pressure symptoms. Once detached, the uterus was sequentially placed in full into the container, the rim of the container was externalized through the vagina, and the uterus was then extracted through the device. Of this 693gr uterus, 471gr were removed in one pull of the Claria System. The container was removed transvaginal and then filled with 4 litres of blue dye to identify any potential breaches. The blue dye test results were negative, demonstrating there were no breaches. No mini-laparotomy was required.

Results

A hysterectomy was performed for a large uterus, and the uterus was removed transvaginal using a novel contained bulk tissue extraction system. No mini-laparotomy was required. The blue dye test results were negative, demonstrating there were no breaches on the container.

Conclusions

The Claria System can be used to remove large uterus quickly due to the large cutting diameter and safely due to its "Auto-shutoff" technology. The Claria System demonstrated promising results for safe and fast uterine tissue removal and warrants further investigation.

Seeing Beyond White Light: Evaluating Narrow Band Imaging for Enhanced Detection of Peritoneal Endometriosis

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Background

Endometriosis affects up to 10% of reproductive-aged women, with diagnosis often delayed by years due to non-specific symptoms and the limitations of conventional diagnostic modalities. Laparoscopy remains the gold standard, yet under white light imaging, subtle peritoneal lesions—particularly early or non-pigmented disease—may be overlooked. Narrow Band Imaging (NBI) is an advanced optical modality that uses filtered light at 415–540 nm to enhance mucosal microvasculature and capillary patterns. Given the inherent angiogenic activity of endometriosis, NBI may improve intraoperative lesion detection and facilitate more complete excision.

Objective:

To systematically evaluate the evidence on the effectiveness of NBI in improving intraoperative detection of peritoneal endometriosis during laparoscopy. **Methods**

A systematic literature search was conducted in MEDLINE, EMBASE, and Cochrane databases, using search terms including “narrow band imaging,” “laparoscopy,” and “endometriosis.” Studies were included if they evaluated the use of NBI in endometriosis surgery and reported outcomes on diagnostic accuracy, lesion detection, or histological correlation. Both prospective and retrospective studies were considered. Data extraction included study design, patient population, detection rates under white light vs NBI, histological confirmation, and reported safety outcomes.

Results

Seven studies met inclusion criteria, encompassing over 450 patients undergoing laparoscopic evaluation or treatment for suspected endometriosis. NBI identified additional peritoneal lesions in 19–48% of patients compared to white light alone. Histologically confirmed endometriosis was reported in 61–85% of NBI-identified lesions. The technique was particularly effective in highlighting subtle, non-pigmented lesions often missed under standard visualisation. In one prospective cohort, the use of NBI after white light survey increased the total number of excised lesions by 28%. Importantly, no NBI-related complications or adverse events were reported across all studies. Some studies noted a learning curve and operator dependency, though inter-observer agreement improved with experience.

Conclusions

NBI appears to be a safe, feasible adjunct to standard laparoscopy and may significantly enhance intraoperative detection of peritoneal endometriosis. Its ability to highlight early or inconspicuous lesions could support more complete resection, potentially reduce recurrence and improving long-term outcomes. Wider adoption may also benefit surgical training, offering real-time enhanced visualisation for junior surgeons. However, larger, randomised controlled trials are essential to determine the impact of NBI on surgical completeness, symptom recurrence, and quality of life. Integration of NBI into high-volume endometriosis centres could represent a significant step forward in improving diagnostic and therapeutic accuracy in this complex disease.

A new path: post-hysterectomy vaginal cuff indocyanine green injection

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Background

The standard management of patients with early-stage cervical cancer is a hysterectomy with lymph node assessment.^{1,2} Also, sentinel lymph node (SLN) biopsy has been a standard approach in the surgical staging of endometrial cancer (EC).³ SLN dissection allows ultra-staging of the lymph node(s) that detects micro metastasis and isolated tumor cells that the standard Hematoxylin&Eosin technique could not find. SLN mapping is performed before hysterectomy in current practice. This video explores the possibility of performing SLN mapping after a hysterectomy.

Methods

A 59-year-old woman with abnormal uterine bleeding and multiple uterine myomas could not be biopsied preoperatively because of cervical stenosis. Therefore, surgery was planned, and a laparoscopic hysterectomy with BSO was performed. In the intraoperative frozen section, grade-1 EC was detected. Intraoperative gynecologic oncology consultation was requested.

Results

A submucosal vaginal cuff ICG injection was performed. Bilateral SLNs were detected. Definitive pathology revealed no lymphatic metastasis. Therefore, no adjuvant therapy was given.

Conclusions

To the best of our knowledge, SLN biopsy after a previous simple hysterectomy for cervical cancer has not been reported in the literature. In the case of incidental cervical cancer or EC, ICG injection into the submucosa of the vaginal vault for SLN mapping is feasible, both during and after the initial operation. The previous hysterectomy might not be an obstacle for SLN mapping, and this concept deserves further well-designed prospective studies.

<https://player.vimeo.com/video/1090147367?autoplay=1>

Conservative Fluorescent Guided Surgery for ovarian Fibromas

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Background

Ovarian fibromas are benign pathology generally treated by laparoscopy. Two surgical options are available; oophorectomy for mature patients or oophoroplasty in younger patients who desire to spare her fertility. The size and shape of the fibromas could impose technical challenges. The persistence of abnormal ovarian tissue could regenerate fibrotic lesions, estimated in 1-4% of all oophoplasties. Considering the perfusion difference between the normal ovarian parenchyma and the fibrotic pathology, we suggest a fluorescence guided surgery technique to enhance the visualization and preserve normal ovarian tissue

Methods

Twelve young patients (16 to 37 seven years old) diagnosed with ovarian fibromas by ultrasound or MRI scan were submitted to video laparoscopy with a 4K Near Infrared (NIR) Camera . During the procedure, both ovaries were inspected with normal light. Then 10mg of Indocyanine Green Dye was injected intravenously and the fluorescent contrast image mode was turned on for a new inspection of both ovaries. The proposed oophoplasties were performed sometimes with the help of contrast mode in more tricky situations. One patient was upscaled to unilateral oophorectomy due a different ICG image evolving all the ovary. All the surgical specimens were analysed by pathologist after the surgery.

Results

Eleven patients with different presentations of fibromas were submitted to oophoplasties - all confirmed with typical ovarian fibromas by pathologist. One patient with prior surgical proposition of oophoroplasty was upscaled to oophorectomy due to an atypical ICG image in contrast mode - final diagnose of ovarian myoma affecting all the ovary. In three patients with use of ICG fluorescent image we discovered another fibrotic areas that could be left behind - in those three patients we prefer to proceed the surgery in fluorescent high contrast mode to guide us during the resections for better identification of healthy tissue ovarian boundaries.

Conclusions

The use near infrared camera with 4K resolution, in contrast mode, with Indocyanine Green Dye help identify boundaries of the fibrotic lesion, search other fibrotic areas that could be left behind, preserving more healthy tissue and maybe reducing the persistence / incidence of ovarian fibromas. in a future, with proper protocols, could also help in a surgical evaluation of suspect ovarian masses .

Sentinel Lymph Node Dissection with Methylene Blue in Endometrial Cancer

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Background

Sentinel lymph node (SLN) mapping has emerged as a valuable technique in endometrial cancer staging, aiming to reduce surgical morbidity while maintaining diagnostic accuracy. Intraoperative mapping using methylene blue dye enables targeted SLN removal and may limit the extent of pelvic lymphadenectomy and its associated complications.

Methods

A 62-year-old woman diagnosed with endometrial carcinoma underwent laparoscopic surgical staging under general anaesthesia. Methylene blue was injected into the cervix at the 3 and 9 o'clock positions. A uterine manipulator was placed, and pneumoperitoneum was established via a 10 mm umbilical port, followed by the placement of three additional 5 mm trocars.

Laparoscopic inspection revealed a normal-sized uterus and adnexa. Peritoneal washings were collected. Bilateral salpingo-oophorectomy and retroperitoneal dissection were performed. The pelvic sidewalls were opened to expose the iliac vessels, and methylene blue-stained sentinel lymph nodes were identified bilaterally. These nodes were dissected and retrieved using a glove-finger specimen pouch via a 5 mm port.

An infracolic omentectomy was then carried out. The vesicouterine peritoneum was incised, and bilateral uterine arteries were skeletonized, coagulated, and divided. Colpotomy was performed with hook cautery, and the uterus, adnexa, and omentum were removed transvaginal. The vaginal cuff was closed intracorporeally. A drain was placed in the pouch of Douglas, and the procedure was completed laparoscopically without complications.

Results

The operation lasted 120 minutes and was completed without intraoperative complications. Sentinel lymph nodes were clearly visualized and successfully excised. Blood loss was minimal, and both ureters were confirmed to be anatomically intact. The patient had an uneventful postoperative course, and all surgical specimens were sent for pathological examination.

Conclusions

Laparoscopic SLN dissection with methylene blue is a safe and effective technique for surgical staging in endometrial cancer. It allows accurate identification of lymphatic pathways while minimizing the need for extensive lymphadenectomy in selected patients. This case illustrates that with meticulous technique and anatomical dissection; sentinel nodes can be reliably identified and removed laparoscopically. The procedure also facilitates comprehensive staging—including hysterectomy, adnexectomy, and omentectomy—through a minimally invasive approach, supporting its adoption in the routine surgical management of early-stage endometrial cancer.

<https://player.vimeo.com/video/1085842114?autoplay=1>

Fluorescence-Guided Robotic-Assisted Surgery for Pelvic Schwannomas: A Minimally Invasive Approach to Safe and Complete Resection

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Background

Pelvic schwannomas are rare retroperitoneal tumors presenting diagnostic and surgical challenges due to their deep anatomical location and proximity to critical structures. Optimal management typically involves complete surgical excision. This study demonstrates the feasibility and effectiveness of robotic-assisted schwannoma resection utilizing indocyanine green (ICG) fluorescence to improve intraoperative visualization and precision.

Methods

A 47-year-old female patient presented with persistent severe pelvic pain and mild urinary symptoms. Preoperative magnetic resonance imaging (MRI) identified a 5 centimetres retroperitoneal schwannoma situated adjacent to the right hypogastric vein and nerve. A robotic-assisted transperitoneal surgical approach was selected to enhance surgical precision. Immediately before initiating retroperitoneal dissection, 6 milligrams of ICG were intravenously administered to facilitate tumor identification and vascular delineation. Meticulous dissection under fluorescence-guided visualization was carried out, enabling precise excision while minimizing the risk of damage to adjacent neurovascular structures. The excised schwannoma was removed transvaginal via colpotomy, thus avoiding additional abdominal incisions.

Results

The intraoperative use of ICG fluorescence significantly improved the distinction between tumor tissue and surrounding anatomical structures, facilitating a safer and more precise dissection. The robotic system provided enhanced dexterity and magnification, allowing for meticulous tumor mobilization and complete capsule removal without neurovascular injury. The operative course was uneventful, with no intraoperative complications or significant blood loss. The patient was discharged on postoperative day one without complications. Histopathological analysis confirmed a benign schwannoma with negative margins. Follow-up imaging over the standard surveillance period demonstrated no evidence of recurrence.

Conclusions

Robotic-assisted pelvic schwannoma excision using ICG fluorescence enhances intraoperative visualization, precision, and patient safety. The minimally invasive approach combined with transvaginal specimen extraction reduces surgical morbidity and accelerates postoperative recovery. These results support robotic surgery augmented by ICG as a preferred approach in managing retroperitoneal pelvic schwannomas, although larger series and long-term follow-up studies are necessary to confirm these findings.

<https://player.vimeo.com/video/1085454663?autoplay=1>

Sentinel Lymph Node Mapping using Indocyanine Green (ICG) Fluorescence with the Hugo RAS system in Endometrial Cancer Staging: a World Premiere Video Case Report

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Background

Minimally invasive surgery is the preferred approach to early-stage endometrial cancer (EC) staging, with robot-assisted surgery (RAS) increasingly adopted due to its benefits for both patients and surgeons.

Specific benefits for EC staging include a lower conversion rate and a faster recovery when compared to laparoscopy, especially in obese patients. These benefits may substantiate the additional costs required for RAS.

The Hugo RAS™ system recently enabled the use of indocyanine green (ICG) near-infrared fluorescence (NIRF) with the installation of the TIPCAM®1 RUBINA™, a high-resolution laparoscope for ICG-NIRF imaging.

Current ESGO-ESTRO-ESP guidelines support sentinel lymph-node (SLN) biopsy with ICG for staging in low-risk and intermediate-risk EC, and this novel system may be used to further enhance the validity of this approach.

Methods

We present the case of a 47-year-old woman with grade 1 endometrioid EC who underwent robot-assisted total hysterectomy, bilateral salpingo-oophorectomy, and SLN dissection. A four-arm robotic configuration was chosen following the “compact bridge” docking configuration. ICG was injected into the cervix for NIRF SLN mapping. A uterine manipulator was used, as part of an ongoing randomized trial (MANEC).

Results

Total operative time was 110 minutes. Time at the robotic console was 80 minutes. Docking time was 5 minutes. Estimated blood loss was 50mL. No intraoperative or postoperative complications were noted. The patient was discharged on postoperative day 2. Final pathology results showed a FIGO stage IA endometrioid endometrial adenocarcinoma. Two SLNs were bilaterally harvested in the obturator fossae, both negative for metastasis.

Conclusions

This was the world's first successful use of ICG fluorescence imaging with the Hugo RAS™ system for SLN mapping in EC staging.

Prospective and larger studies in the future are necessary to quantify such benefits via a comparison with other robotic systems.

The effective integration of ICG fluorescence imaging with the robotic surgical systems serves as an invaluable teaching tool to accelerate the learning curve and to educate young surgeons regarding complex surgical concepts such as SNL biopsy in gynecologic oncology.

<https://player.vimeo.com/video/1085819254?autoplay=1>

Fluorescence-Guided Ureteral Identification Using ICG in Robotic Sacrocolpopexy with the Hugo™ RAS System: A Video Case Report

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Background

Fluorescence-guided surgery through indocyanine green (ICG) has been increasingly studied and applied in robotic and laparoscopic pelvic surgery, including sentinel lymph node biopsy in malignancies, assessment of vascular perfusion in structures such as the ureters, bowel and ovaries, and identification of critical structures.

Recently, the use of intraoperative cystoscopic intraureteral ICG instillation combined with near-infrared fluorescence imaging has been shown to facilitate real-time identification of the ureters and bladder during robotic and laparoscopic surgeries, thereby reducing the risk of iatrogenic injuries. The recent integration of Rubina™ technology has enabled fluorescence-guided surgery with ICG into the Hugo™ Robotic-Assisted Surgery (RAS) system. The Karl Storz Image1 S Rubina™ system offers three NIR/ICG imaging modes—Overlay (blue/green), Monochromatic, and Intensity Map—each controllable via foot pedal or camera-mounted buttons.

In this context, we present a video of a woman affected by pelvic organ prolapse and uterine fibroids compressing the right ureter, undergoing robotic sacrocolpopexy, highlighting the intraureteral injection of ICG and the use of NIR imaging during robotic surgery performed with the Hugo™ RAS system.

Methods

A 60-year-old multiparous woman presented with symptomatic multicompartimental POP (POP-Q stage 3). Preoperative ultrasound revealed a posterior subserous isthmic fibroid, approximately 5 cm in size, near the right ureter. After a comprehensive preoperative evaluation, the patient underwent a subtotal hysterectomy with bilateral adnexectomy and sacrocolpopexy using the Hugo RAS system (MEDTRONIC Inc, USA). Prior to the surgical procedure, indocyanine green (ICG) was injected into both ureters through cystoscopy.

A 4-F open-ended ureteral catheter was placed in the right ureteral orifice through the operating channel. A mixture of 5-6 cc of ICG (25 mg ICG dissolved in 10 cc of sterile water) was injected into the middle ureter and the catheter was slowly withdrawn. During the robotic procedure, the fluorescent right ureter was highlighted in real time.

Results

The surgical procedure was completed without any intraoperative complications. No system errors or faults in the robotic arms were recorded. Operative time (OT) was 160 minutes, docking time was 8 minutes, and estimated blood loss (EBL) was 20 ml. The postoperative course was uneventful, and the patient was discharged two days later.

Conclusions

The intra-ureteral injection of indocyanine green (ICG) via cystoscopy, performed prior to robotic sacrocolpopexy, may serve as a valuable technique for visualizing the ureteral course. This is especially critical in cases like the one described, where the ureter may be compressed by a myometrial mass. Furthermore, ICG enhances the identification of the bladder trigone, marking the caudal boundary of dissection during the preparation of the anterior plane for the placement of the anterior mesh.

This approach provides real-time, precise guidance, ensuring optimal surgical outcomes and minimizing the risk of ureteral injury.

<https://player.vimeo.com/video/1085767282?autoplay=1>

The Role of LED-Illuminated Uterine Manipulators in Laparoscopic Hysterectomy: A Case Report and Technical Review

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Background

Uterine manipulators have become indispensable tools in modern gynecologic surgery, particularly for procedures such as laparoscopic hysterectomies and myomectomies. This study examines the specific advantages offered by LED-illuminated uterine manipulators, focusing on their ability to enhance surgical precision, improve anatomical visualization, and reduce complication rates. We present a detailed case analysis along with a technical review of this innovative surgical instrument.

Methods

We conducted a prospective case study of a 48-year-old patient with one previous caesarean delivery who presented with abnormal uterine bleeding secondary to a large (77×70 mm) intramural-subserosal myoma. The patient underwent total laparoscopic hysterectomy utilizing a next-generation LED-illuminated uterine manipulator). Key surgical steps included: systematic coagulation and transection of bilateral infundibulopelvic and round ligaments using advanced bipolar energy; careful development of the vesicovaginal space under direct LED illumination; precise identification and transection of uterine arteries; and circumferential colpotomy guided by the illuminated vaginal fornix demarcation. The procedure concluded with intracorporeal suturing of the vaginal cuff.

Results

The LED illumination clearly identified vaginal fornices and the vesicovaginal space, enabling precise colpotomy and safe dissection. No intraoperative complications occurred, with complete visualization of critical structures throughout the procedure. The manipulator-maintained pneumoperitoneum and optimized surgical exposure.

Conclusions

Our experience demonstrates that LED-illuminated uterine manipulators represent a significant advancement in laparoscopic gynecologic surgery. The integrated lighting system provides unparalleled visualization of critical anatomical structures, particularly during the most challenging phases of hysterectomy. This technology offers three key benefits: Enhanced safety through real-time identification of dissection planes; improved surgical efficiency by reducing time spent on anatomical orientation; consistent reproducibility of optimal surgical outcomes. We recommend the routine use of illuminated manipulators for complex laparoscopic hysterectomies, especially in cases involving large uteri or distorted pelvic anatomy.

<https://player.vimeo.com/video/1085639719?autoplay=1>

Indocyanine Green (ICG)-Guided Laparoscopic Hysterectomy for Adenomyosis in a Patient with a Pelvic Kidney

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Background

Laparoscopic hysterectomy in patients with anatomical anomalies, such as a pelvic kidney, requires meticulous dissection to avoid ureteral injury. Indocyanine green (ICG) fluorescence imaging offers real-time visualization of ureters and can be particularly helpful in complex gynecologic surgeries.

Methods

Laparoscopic hysterectomy with ureteral ICG guidance was planned. A total of 5 mL of ICG at a concentration of 1 mg/mL was injected into each ureter via ureteral catheters. Intraoperative ICG fluorescence allowed clear identification of both ureters, particularly aiding in the dissection of the left ureter near fibrotic tissue. The uterus was extracted vaginally, and the vaginal cuff was closed in two layers using 0 Vicryl in a running fashion. The right ovary was fixated to the round ligament to prevent torsion.

Results

The procedure was completed without complications. ICG fluorescence played a crucial role in preventing ureteral injury, especially in the setting of distorted pelvic anatomy due to adenomyosis and the presence of a pelvic kidney.

Conclusions

ICG fluorescence-guided surgery is a valuable technique for safe ureteral identification and preservation in complex gynecologic cases involving anatomical anomalies, such as pelvic kidneys and severe adenomyosis.

<https://player.vimeo.com/video/1084674888?autoplay=1>

Management and Outcomes of Rare Extra-Pelvic Endometriosis: A Case Series from The Endometriosis Centre at Birmingham Women's Hospital

Marwa Mohamed¹, Lina Antoun¹, Yousri Afifi¹

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Aim

To highlight the varied clinical presentations, diagnostic approaches, surgical management strategies, and patient outcomes in rare forms of extra-pelvic endometriosis, contributing to the existing literature and aiding in the recognition and effective management of these unusual cases.

Background

Extra-pelvic endometriosis, defined as the presence of endometrial-like tissue outside the pelvis, is a rare manifestation of a common gynaecological condition. Its diverse and often enigmatic presentations can lead to diagnostic delays and therapeutic challenges. This case series discusses the treatment and outcomes of three distinct cases of extra-pelvic endometriosis involving the diaphragm, the bladder, and a hernial sac.

Materials / Patients

Video uploaded

Methods / Results

This paper presents a retrospective case series of three patients diagnosed with extra-pelvic endometriosis at the endometriosis centre at Birmingham Women's Hospital. The cases include: (1) diaphragmatic endometriosis causing cyclical thoracoabdominal pain and catamenial pneumothorax; (2) endometriosis affecting the bladder; (3) Hernial sac endometriosis. We detail the diagnostic workup, including imaging and histopathological confirmation, the specific surgical interventions undertaken for each case, and a summary of the post-operative outcomes and follow-up.

Discussion

These three cases from Birmingham Women's Hospital, highlight the diagnostic complexity and the necessity for individualised, often multidisciplinary, surgical approaches in managing rare extra-pelvic endometriosis. While challenging, appropriate surgical intervention can lead to significant symptom relief and improved outcomes for patients with these uncommon presentations. Increased awareness and a high index of suspicion are crucial for timely diagnosis and effective treatment.

Conclusion

All three patients underwent surgical management tailored to the location and extent of their endometriosis. The patient with diaphragmatic endometriosis underwent treatment with thermal coagulation using a low-power helium plasma beam to destroy endometrial tissue without making direct contact. The patient with bladder endometriosis underwent excision of the endometriotic deposit. The patient with a hernia sac endometriosis required excision of the hernial sac with the endometriosis. Histopathological examination confirmed the presence of endometriosis in all cases. Post-operatively, all patients reported significant improvement in their primary symptoms and an enhanced quality of life. Follow-up duration and specific outcome measures for each case are presented

Impact to Patients' Health

Quality of life questionnaire outcome pending

<https://player.vimeo.com/video/1092686598?autoplay=1>

Outcomes of Flexible Sigmoidoscopy or Colonoscopy in Women with Endometriosis and Bowel Involvement in a London hospital, 2019–2023.

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Background

Bowel involvement in endometriosis, estimated to affect 3–35% of patients with the disease, often presents with nonspecific gastrointestinal symptoms. Flexible sigmoidoscopy or colonoscopy is occasionally used preoperatively in suspected deep infiltrating endometriosis (DIE), despite limited evidence supporting its routine use.

Methods

A retrospective analysis was conducted on 41 women (42 procedures) discussed at a multidisciplinary team (MDT) meeting between 2019 and 2023 in a London hospital. All patients underwent pelvic MRI prior to endoscopic evaluation. Symptomatology, MRI findings, endoscopic and histological outcomes, and hormonal treatments were analysed.

Results

76% of patients reported bowel-related symptoms including dyschezia and tenesmus. MRI confirmed bowel involvement in all patients (n=42), primarily within six months prior to endoscopy. Despite this, no endoscopic findings related to endometriosis were identified. Eight patients had biopsies; none revealed sinister pathology. 85% (n=35) received hormonal treatment, with 69% initiating therapy within 6 months of endoscopy, potentially influencing findings.

Conclusions

In this cohort, flexible sigmoidoscopy or colonoscopy did not yield additional clinically useful information for the management of endometriosis with bowel involvement. Routine endoscopic evaluation may have limited value, particularly in the context of recent MRI imaging and hormonal treatment.

Surgical Management of Deep Infiltrating Endometriosis with Ureteral and Bladder Involvement: Hysterectomy and Bilateral Salpingo-Oophorectomy

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Background

The surgical treatment of deep infiltrating endometriosis involving the bladder and ureters remains unstandardized, with techniques differing widely across medical centres. In such cases, performing a hysterectomy with bilateral salpingo-oophorectomy along with total excision of endometriotic nodules can result in serious complications, including ureterovaginal and vesicovaginal fistulas, which have a profound impact on a patient's quality of life. These complications are often the result of inadequate bladder repair following perforations or improperly executed ureteral reanastomosis. This video presents a laparoscopic approach to treating deep infiltrating endometriosis, focusing on a partial bladder resection and the removal of ureteral endometriotic lesions. The patient provided informed consent for the use of the video, and the authors report no conflicts of interest.

Methods

A 45-year-old woman, gravida 1 para 1, with a 15-year history of endometriosis presented with symptoms of pelvic pain, dysuria, and dyspareunia, particularly aggravated during menstruation. Her medical history includes a prior laparoscopic procedure for endometriosis, an appendectomy, and a caesarean section. MRI findings revealed two clearly defined nodular lesions measuring 5 mm and 4 mm on the posterior wall of the bladder. Preoperative cystoscopy showed normal ureteral orifices and bladder mucosa, but areas of extrinsic compression were observed beneath the left ureteral orifice and along the left lateral bladder wall. The patient's CA-125 level was elevated at 170 u/mL. Considering her reported pain significantly impairing her social life and her preference to prioritize daily function over fertility, a laparoscopic bilateral salpingo-oophorectomy was scheduled, along with excision of endometriotic lesions involving the bladder and ureter.

Results

The operation took 158 minutes to complete, with a blood loss of 240 mL. The patient was discharged five days after surgery without any complications. Pathological examination confirmed the presence of endometriosis and an endometriotic nodule affecting the bladder and ureter.

Conclusions

Laparoscopic surgery is a viable option for treating deep infiltrating endometriosis in carefully chosen patients. This technique, which demands both technical expertise and perseverance, provides substantial benefits, particularly in cases involving genitourinary tract invasion.

<https://player.vimeo.com/video/1090287800?autoplay=1>

Management and Outcomes of Rare Extra-Pelvic Endometriosis: A Case Series from The Endometriosis Centre at Birmingham Women's Hospital

Marwa Mohamed¹, Lina Antoun¹

¹Birmingham Women's Hospital, Gynaecology Department, Birmingham, United Kingdom

Background

Background: Extra-pelvic endometriosis, defined as the presence of endometrial-like tissue outside the pelvis, is a rare manifestation of a common gynaecological condition. Its diverse and often enigmatic presentations can lead to diagnostic delays and therapeutic challenges. This case series discusses the treatment and outcomes of three distinct cases of extra-pelvic endometriosis involving the diaphragm, the bladder, and a hernial sac.

Objective: To highlight the varied clinical presentations, diagnostic approaches, surgical management strategies, and patient outcomes in rare forms of extra-pelvic endometriosis, contributing to the existing literature and aiding in the recognition and effective management of these unusual cases.

Methods

This paper presents a retrospective case series of three patients diagnosed with extra-pelvic endometriosis at the endometriosis centre at Birmingham Women's Hospital. The cases include: (1) diaphragmatic endometriosis causing cyclical thoracoabdominal pain and catamenial pneumothorax; (2) endometriosis affecting the bladder; (3) Hernial sac endometriosis. We detail the diagnostic workup, including imaging and histopathological confirmation, the specific surgical interventions undertaken for each case, and a summary of the post-operative outcomes and follow-up.

Results

All three patients underwent surgical management tailored to the location and extent of their endometriosis. The patient with diaphragmatic endometriosis underwent treatment with thermal coagulation using a low-power helium plasma beam to destroy endometrial tissue without making direct contact. The patient with bladder endometriosis underwent excision of the endometriotic deposit. The patient with a hernia sac endometriosis required excision of the hernial sac with the endometriosis. Histopathological examination confirmed the presence of endometriosis in all cases. Post-operatively, all patients reported significant improvement in their primary symptoms and an enhanced quality of life. Follow-up duration and specific outcome measures for each case are presented.

Conclusions

These three cases from Birmingham Women's Hospital, highlight the diagnostic complexity and the necessity for individualised, often multidisciplinary, surgical approaches in managing rare extra-pelvic endometriosis. While challenging, appropriate surgical intervention can lead to significant symptom relief and improved outcomes for patients with these uncommon presentations. Increased awareness and a high index of suspicion are crucial for timely diagnosis and effective treatment.

Giant Left Ovarian Endometrioma in a Reproductive-Aged Woman: A Laparoscopic Solution to a Diagnostic and Surgical Dilemma

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Background

The surgical management of ovarian endometriomas is often part of a comprehensive approach to endometriosis. Isolated endometriomas are rare. Laparoscopic cystectomy remains the gold standard for surgical treatment. However, this technique may impair ovarian function. Hemostasis of the cyst bed should be performed with care to preserve the ovarian stroma.

Methods

We performed the procedure using an excisional technique. The endometrioma was first opened, and its contents aspirated. The cavity was irrigated thoroughly. Using two grasping forceps, bimanual and counter-traction were applied to identify the dissection plane between the cyst wall and the ovarian cortex. The cyst capsule was then meticulously stripped from the normal ovarian tissue, sutured, and removed in an endobag.

Results

A laparoscopic ovarian cystectomy was successfully performed. The patient was discharged on postoperative day two. At follow-up, she demonstrated significant improvement in her symptoms. Pregnancy could not be assessed as the patient does not currently desire fertility.

Conclusions

Although the optimal treatment strategy for ovarian endometriomas remains controversial, laparoscopy continues to be the gold standard in surgical management. Endometrioma surgery is a technically demanding and evolving procedure that benefits from advanced laparoscopic techniques. The surgical goal should always be to minimize damage to the ovarian cortex. Excisional approaches significantly reduce recurrence risk compared to ablative techniques. Hormonal suppression with progesterone preparations may be considered to prevent recurrence until pregnancy is planned.

<https://player.vimeo.com/video/1089816586?autoplay=1>

Medical versus Surgical management of Rectal endometriosis and digestive functional outcomes: a randomized controlled trial (MESURE)

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Background

Deep endometriosis infiltrating the rectum (DEIR) may be managed by medical treatment or surgical excision. Comparative data concerning functional outcomes of these two approaches are scarce in terms of improvement of rectal function. To provide new information in this field, we report the results of a randomized controlled trial (RCT) comparing the two approaches (NCT01973816).

Methods

Patients with symptomatic DIER and no pregnancy wish were randomly allocated to either surgical excision (followed by 24 months of progestin to prevent recurrences, SU) or medical treatment (3 months of GnRHa followed by 18 months of progestin intake; ME). Outcomes were assessed at 24 months in intention to treat.

Results

There were enrolled 36 women in the SU arm (receiving 19 shavings, 7-disc excisions and 10 rectal resections) and 38 women in the ME arm. In the ME arm, 17 patients (44.7%) ultimately received a surgery during the follow up because the lack of hormonal treatment's efficiency. Hysterectomy rates were 41.7% vs. 31.6%. Reoperation rate was 8.3% vs 2.9%.

In the two arms, severe adverse events rates related to surgical treatment were 11% vs. 18.4%, and those that could be related to hormonal treatment were 13.9% vs 7.9%. Intracranial meningiomas occurred in 8.3% vs. 5.3% with consecutive arrest of hormonal treatment.

Improvement of digestive function, pelvic pain and quality of life was comparable between the two arms.

Conclusions

Surgical excision and hormonal treatment may be proposed in symptomatic DIER. When medical treatment is recommended, half of patients can receive surgery within 2 years for unsatisfactory improvement of complaints. Patients must be informed about the risk of adverse events, among which meningioma occurrence requires the arrest of hormonal treatment.

Deep infiltrating endometriosis of the left sciatic nerve combined laparoscopic and transgluteal approach

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Background

To show how deep infiltrating endometriosis of the left sciatic nerve can be safely managed combined laparoscopic and transgluteal approach. Informed consent was obtained from the patient. The authors declare no conflict of interest.

Methods

We present a case of a 46-year-old patient with a two-year history of symptoms, including severe pain (VAS score of 10) and functional impairment of the left lower limb. The patient had been undergoing treatment with Visage for six months, with worsening functional impairment despite the treatment. A pelvic MRI revealed endometriotic lesions compressing the left sciatic nerve, extending outside the pelvis through the sciatic foramen.

To completely remove the endometriotic lesions, we decided on a combined laparoscopic and transgluteal approach. During the procedure, we opened the retroperitoneum and identified the anatomic landmarks. We carefully dissected the ureter and the pararectal fossa, identifying the obturator nerve, followed by the obturator artery and vein. Care was taken to avoid significant bleeding during the dissection of these structures.

As the dissection progressed, we reached the pelvic sidewall and identified the ischiococcygeal muscle. A lymphatic node obstructing access to the hypogastric vein was dissected and gently removed. To improve access to the sciatic nerve, we decided to sacrifice the obturator artery and vein. Hem-o-lok clips were placed on the obturator vein, obturator artery, and internal iliac vein. The obturator artery and vein were then divided using the Harmonic scalpel, allowing us to continue the dissection of the sciatic nerve.

The presence of endometriotic lesions was confirmed by the appearance of a brownish liquid. The fibrotic tissue compressing the nerve was carefully dissected and removed using scissors to avoid thermal damage. The Harmonic scalpel was also used judiciously.

After that we proceeded with the transgluteal approach. The skin and fat tissue were incised, and the fibres of the gluteal muscle were divided to access the sciatic nerve. The nerve was identified, marked, and the compressing fibrotic tissue was gently dissected and excised completely.

Results

Postoperatively, the patient showed significant improvement in pain and regained functionality of the affected limb.

Conclusions

The management of deep infiltrating endometriosis involving the left sciatic nerve requires a meticulous and multidisciplinary approach. The combined laparoscopic and transgluteal strategy allows for comprehensive excision of endometriotic lesions while preserving nerve function and minimizing complications. This technique offers a safe and effective option for addressing complex cases, significantly improving pain and functional outcomes for patients.

<https://player.vimeo.com/video/1085838938?autoplay=1>

Endometriosis-related infertility: when surgery becomes a necessity

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Background

To present a complex case of deeply infiltrating endometriosis (DIE) in a 40-year-old woman with infertility and chronic pelvic pain, and to evaluate the role of surgery in achieving spontaneous conception in accordance with the 2022 ESHRE recommendations.

Methods

A 40-year-old woman with a three-year history of infertility, autoimmune thyroiditis and luteal-phase progesterone deficiency underwent expert transvaginal ultrasound, revealing advanced DIE with #ENZIAN(u): Px; O1/1; T3/3; A2; B2/2; C3; FA. Pain was assessed via the Visual Analogue Scale (VAS): dysmenorrhea 5/10, dyschezia 5/10, dyspareunia 4/10, dysuria 3/10. Given the advanced stage of the disease, the patient was counselled regarding the ESHRE 2022 guidelines, the role of assisted reproductive technologies (ART), and the potential indications (pelvic pain symptoms) for surgical intervention with information that no compelling evidence exists that operative laparoscopy for DE improves fertility. The patient wished to conceive naturally. Suppressing hormonal therapy was avoided, in accordance with current recommendations. In cases of surgical management, the Endometriosis Fertility Index (EFI) is recommended to assess fertility prognosis; however, this index can only be determined postoperatively.

Results

Three months later, the patient experienced worsening gastrointestinal symptoms and increased dyspareunia, prompting a decision for surgical treatment. Laparoscopic excision of all endometriotic lesions—including a 12 cm segmental rectal resection—was performed over five hours. Postoperative recovery was uneventful; the patient resumed oral intake and passed stool on day 1. No suppressive hormonal therapy was initiated. Within the first menstrual cycle following surgery, she achieved a spontaneous pregnancy.

Conclusions

Endometriosis-related infertility is multifactorial, involving oxidative stress, chronic inflammation, hormonal resistance, altered microbiota, impaired gamete transport and anatomical distortion. While ART is a key component in treatment, surgery may significantly improve the chances of spontaneous conception in selected patients, particularly those with DIE and significant symptoms. Surgical intervention should be individualized, with careful consideration of patient goals and disease severity. This case underscores the importance of shared decision-making: integrating patient preferences and current guidelines in endometriosis management.

Techniques of Laparoscopic Adenomyomectomy

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Background

This study presents two cases illustrating a novel laparoscopic adenomyomectomy technique for the management of focal uterine adenomyosis in women with severe symptoms and a desire to preserve fertility.

Methods

The first case involved a 35-year-old woman presenting with severe pelvic pain, heavy menstrual bleeding, vomiting, and fainting episodes. Imaging revealed a 3.5 cm focal adenomyosis in the posterior uterus. Despite 6 months of oral contraceptive use, her symptoms persisted. Her AMH level was 0.8 ng/ml, and she had no history of pregnancy. Laparoscopic adenomyomectomy was planned. During surgery, desmopressin was injected into the affected area. An incision was made on the uterus to divide the adenomyotic lesion, which was then excised in two halves by identifying a proper cleavage plane, without entering the endometrial cavity. The myometrial defect was closed with continuous barbed sutures (V-Loc), and a hemoclip was applied. Specimens were removed via colpotomy through the rectovaginal space. The second case involved another 35-year-old woman with multiple uterine myomas and a deep endometriosis nodule. After performing myomectomies, bilateral ureterolysis and uterine artery dissection were carried out. The endometriosis nodule, closely associated with a focal adenomyosis, was excised using monopolar cautery. A colpotomy was required for specimen retrieval, which was sutured post-excision.

Results

At 3-month follow-up, patients reported resolution of their pain and bleeding. Pathology confirmed both cases results are adenomyosis.

Conclusions

With increasing emphasis on fertility preservation, laparoscopic adenomyomectomy is emerging as a minimally invasive and effective alternative to laparotomy for treating focal adenomyosis. However, standardized surgical techniques are still lacking. This report introduces an advanced laparoscopic adenomyomectomy approach and highlights its feasibility, safety, and clinical benefits in carefully selected cases.

<https://player.vimeo.com/video/1085410436?autoplay=1>

The New Technique of Endometrioma Stripping

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Background

Endometriotic ovarian cysts, or endometriomas, are common Gynecological conditions in reproductive-aged and infertile women. Laparoscopic stripping cystectomy remains the gold-standard surgical approach for ovarian endometriosis. However, the method of hemostasis used during surgery significantly affects the ovarian reserve. Bipolar electrocoagulation, though commonly applied, has been shown to negatively impact ovarian function, and its use should be minimized, particularly in women with future fertility aspirations.

Methods

In our surgical approach, we begin by mobilizing the ovary from the pelvic sidewall or ovarian fossa. Following the aspiration of cystic contents, we perform a central incision on the inner cyst layer to fully expose the cyst cavity. The cyst wall is then divided into two halves. Each half is stripped carefully, without thermal energy, while preserving the natural tissue planes between the cyst wall and ovarian cortex. After complete excision, the ovary is reconstructed using barbed sutures (e.g., V-Loc), again avoiding the use of energy.

Results

For large cysts with thick walls, suturing begins from the ovarian inner tissue to prevent postoperative hematoma. For smaller cysts, direct closure of the ovarian serosa is sufficient. Non-thermal methods or suturing techniques are considered more favourable for preserving ovarian tissue.

Conclusions

This systematic stripping technique facilitates the complete removal of the cyst wall, particularly in large endometriomas, and avoids intraoperative confusion during dissection. The surgical goal extends beyond the removal of the endometrioma to include preservation of ovarian reserve and future reproductive potential. Individualized counselling and treatment planning are essential to align surgical interventions with the patient's symptoms and fertility goals.

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Total laparoscopic hysterectomy, bilateral salpingo-oophorectomy, Excision of recto-vaginal endometriosis, and Rectal Shave

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Background

To present an intriguing case through a video demonstration of the above procedure. The video highlights key surgical techniques, including the dissection of para-rectal spaces, separation of the recto-sigmoid colon from the posterior uterine wall, and rectal shaving

Methods

A 45-year-old woman, para 1 following a previous vaginal birth, presented with severe pelvic pain, dysmenorrhoea, dyspareunia, and dyschezia. MRI revealed diffuse adenomyosis and an endometriotic plaque in the region of the uterine torus, tethered to the recto-sigmoid. The plaque measured 2.1 cm in length and 1.2 cm in depth, invading the muscularis layer of the recto-sigmoid while sparing the rectal mucosa.

Following multidisciplinary team (MDT) discussion pelvic clearance was recommended. After consultation in the endometriosis clinic, the patient was given time to consider the proposed treatment and agreed with the MDT's recommendations. Alternative treatment options, including hormonal therapy, were discussed. A referral to colorectal surgeons was made, and flexible sigmoidoscopy confirmed the absence of mucosal involvement.

The patient commenced six months of GnRH analogues prior to surgery. The procedure was performed as a joint operation with the colorectal surgical team. Postoperatively, the patient was initiated on combined hormone replacement therapy (HRT)

Results

Comprehensive counselling was a pivotal aspect of this case. Detailed discussions included explaining the MRI findings, the MDT recommendations, the planned surgical procedure, and potential risks, including the possibility of ileostomy/stoma. The patient was provided sufficient time to consider her options, with follow-up appointments arranged to support her in making a final decision.

Alternative treatment options, such as hormonal therapy, were also presented. However, due to the severity of her symptoms, the patient opted for surgical management. Referral to colorectal surgeons was essential for counselling on stoma-related risks and facilitating a collaborative approach to the joint surgery.

To optimize surgical outcomes, the patient was prescribed six months of GnRH analogues preoperatively to reduce pelvic inflammation. Postoperatively, combined hormone replacement therapy (HRT) was initiated and planned to continue until the age of natural menopause to mitigate the risk of osteoporosis. Despite the hysterectomy, combined HRT was chosen to reduce the risk of endometrioid carcinoma arising from any microscopic endometrial deposits that might not have been fully excised during surgery

Conclusions

This case highlights the management of grade IV endometriosis, emphasizing the surgical techniques employed. It is a valuable educational resource for junior trainees/residents pursuing a career in endometriosis surgery.

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BEST SELECTED ePOSTER

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Fertility-preserving laparoscopic management of intramural pregnancy with hemoperitoneum in the first trimester: A case report

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Background

Intramural pregnancy is an extremely rare and life-threatening form of ectopic pregnancy, accounting for less than 1% of all ectopic cases (Ko et al., 2006). It is characterized by implantation of the gestational sac within the myometrium, typically without communication with the endometrial cavity or fallopian tubes. Early diagnosis is challenging due to non-specific clinical symptoms but is critical to prevent severe complications such as uterine rupture and hemorrhage. Intramural pregnancies are frequently associated with prior uterine surgeries (e.g., curettage, myomectomy) or assisted reproductive techniques, which emphasizes their clinical relevance.

Methods

We report the case of a 33-year-old woman, gravida IV para I, at 9+6 weeks of gestation, who was referred to our unit with sudden, severe abdominal pain. Her obstetric history included one curettage for missed abortion and a second curettage for retained placental tissue. Transvaginal ultrasound revealed a live gestation embedded entirely within the myometrium of the uterine fundus and a substantial haemoperitoneum—findings diagnostic of an intramural ectopic pregnancy (Figures 1 and 2). Due to the patient's haemodynamic instability, an emergency laparoscopic procedure was performed. The patient underwent complete excision of the gestational cavity, right salpingectomy, and multilayer uterine reconstruction to preserve future fertility.



Figure A: Transvaginal sonography showing an intramural ectopic pregnancy in the uterine fundus accompanied by free intraperitoneal fluid indicative of haemoperitoneum.

Figure B and C: Intraoperative image of the firmly adherent, oedematous tube and suture reconstruction of the uterus after complete removal of the pregnancy tissue.

Results

Intraoperatively, a clearly oedematous right tube was found, which was firmly adhered to the uterus. Below the tube, an intact intramural pregnancy extended to the uterine cavity; in addition, there was a pronounced haemoperitoneum. The procedure was completed without complications, and both the intraoperative and postoperative courses were uneventful. A blood transfusion was not necessary. The lowest haemoglobin level postoperatively was 7.7 g/dl. The patient was discharged on postoperative day 3. Histopathology confirmed intramural pregnancy. Serial β -hCG monitoring showed a rapid decline. Contraception was recommended for at least 6 months. Remarkably, the patient conceived spontaneously following recovery, with a planned caesarean section in June 2025.

Conclusions

Intramural pregnancy requires a high diagnostic vigilance, especially in patients with a history of uterine surgery or assisted reproduction. Early laparoscopic management can safely preserve fertility even in emergent cases. This case not only underscores the importance of timely diagnosis and individualized surgical care, but also demonstrates the potential for successful spontaneous conception after conservative surgical treatment—an outcome that highlights the efficacy of the chosen approach.

References:

Ko, H., Lee, Y., Lee, H., Park, I., Chung, D., Kim, S., Park, T., & Shin, J. (2006). Sonographic and MR findings in 2 cases of intramural pregnancy treated conservatively. *Journal of Clinical Ultrasound*, 34(7), 356–360. <https://doi.org/10.1002/jcu.20245>

<https://esge.covr.be/cmdocumentmanagement/conferencemanager/documents/api/getdocument/14582/cmabstsms/0000203660/b68fd4bb688baed9e9b0e566018c2c619a58d31b8e1e9c7c1f55e0cd0af0d31d>

Anti-Müllerian hormone level does not predict complete regression verified by follow-up hysteroscopy in fertility-sparing management of endometrial cancer and endometrial intraepithelial neoplasia

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Background

Recent studies have suggested that Anti-Müllerian hormone (AMH) may act as a tumor suppressor by inhibiting the growth of AMH receptor-expressing endometrial cancer cells. Based on this potential role, this study aimed to evaluate whether serum AMH levels could serve as a predictive biomarker for treatment outcomes in patients with endometrial cancer or endometrial intraepithelial neoplasia (EIN) undergoing fertility-sparing treatment (FST).

Methods

: A retrospective review was conducted on 100 patients diagnosed with endometrial cancer or EIN who received progestin-based FST between 2010 and 2024 at a single institution. Serum AMH levels measured within one year before or after the initiation of hormonal therapy were collected for analysis. Specifically, the study investigated whether AMH levels were associated with complete regression (CR) rates and the time to achieve CR.

Results

A total of 100 patients were included in the analysis. The mean age of the patients was 35.7 ± 4.7 years, and the mean BMI was 25.7 ± 6.1 kg/m². Among the 100 patients, 64 were diagnosed with EIN, 34 with FIGO grade 1 endometrial cancer, and 2 with FIGO grade 2. The most common treatment regimen was medroxyprogesterone acetate (MPA) combined with levonorgestrel-releasing intrauterine system (LNG-IUS) (39.0%), followed by LNG-IUS alone (32.0%) and MPA alone (22.0%). During a mean follow-up period of 30.9 ± 22.1 months, 59 (59%) of patients achieved CR. The average time to CR was 12.6 ± 7.4 months. In univariate and multivariate logistic regression analyses, only BMI was significantly associated with CR success (OR = 0.91, 95% CI: 0.84–0.99, $p = 0.033$). Age, AMH level, histologic type (ECr vs EIN), and treatment type (LNG-IUS vs MPA) were not significantly associated with CR outcomes ($p > 0.05$ for all). The ROC curve analysis yielded an AUC of 0.455, indicating that AMH level had no meaningful predictive power.

Conclusions

AMH levels were not predictive of treatment success or time to CR in patients FST for endometrial cancer or EIN. These findings suggest that AMH may have limited utility as a biomarker for FST outcomes.

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The Diagnostic Accuracy of the Hysteroscopic Morphologic Patterns in Detecting Endometrial Cancer in Women with Abnormal Uterine Bleeding: A Cross-Sectional Study

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Background

Background: To determine the diagnostic accuracy of hysteroscopic morphologic patterns in detecting endometrial cancer in women with abnormal uterine bleeding.

Methods

Methods: Patients diagnosed with abnormal uterine bleeding secondary to endometrial pathology who are referred for hysteroscopy at a tertiary hospital. One hundred forty-five (145) respondents were included.

Descriptive statistics summarized demographic and clinical characteristics using STATA 13.1. Diagnostic accuracy of hysteroscopic findings was assessed with sensitivity, specificity, PPV, NPV, and likelihood ratios.

Results

Result Histopathologic reports of 145 endometrial biopsies, 123 cases (84.8%) were benign; common findings being endometrial polyps (73.98%) and endometrial hyperplasia (9.76%); endometrial carcinoma accounted for 22 cases (15.2%); Grade I (40.91%); Grade III (22.73%) and Grade II (18.18%) using FIGO grading system. Benign findings at 84.8% (n=123); malignant cases at 15.2% (n=22). Endometrial polyps were frequent, (73.98%); endometrial hyperplasia (9.76%) and endometritis (2.43%).

Papillary pattern showed high accuracy (88.28%) with sensitivity of 81.82% and PPV of 58.06%. Its absence had specificity (89.43%) and NPV (96.49%); Glomerular vascular pattern is accurate, with 77.27% sensitivity, 98.37% specificity, PPV of 89.47%, NPV of 96.03%, and positive likelihood ratio (LR+) of 47.52.

Conclusions

Conclusion Hysteroscopic morphologic patterns are significant for predicting endometrial cancer among women with abnormal uterine bleeding, with glomerular vascular pattern to be the most accurate indicator among six patterns studied. Multiple patterns suggest that hysteroscopic findings offer high specificity for endometrial carcinoma, they often have low sensitivity.

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Comparing two hysteroscopic simulation modalities used at a regional gynaecology simulation course at a teaching hospital in Leeds, UK

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Background

This study aimed to compare user experiences and performance outcomes between two hysteroscopy training models: the SAMED synthetic intra-uterine model trainer and the Storz VR virtual reality trainer.

Both simulators are designed to enhance hysteroscopy diagnostic and operative skills. Their goal is to improve proficiency and reduce complication rates through hands-on simulation.

Training candidates at the annual regional gynaecology simulation bootcamp course used both the VR and intra-uterine models during approximately one hour one-to-one hands-on training facilitated by a trainer for each model.

The SAMED model is a non-digital simulation model that creates a life-like synthetic uterine model allowing use of real operative equipment including morcellation and resecting devices in real time while the VR trainer is a virtual reality-based simulator that uses a virtual environment to replicate the experience of performing hysteroscopy procedures in a virtual setting.

Aims

To evaluate participant feedback and experiences across the two hysteroscopy training models.

Methods

Data was collected from questionnaires completed by attendees of the 2024 LTHT Gynaecology Bootcamp. The cohort included 20 candidates and 2 trainers. Data were analysed using Microsoft Excel.

Results

Among candidates, 55% (11) were year 1, 20% (4) year 2, and 25% (5) year 3.

Across both models, the diagnostic hysteroscopy self assessed entrustability levels amongst candidates showed 20% (4) at Level 1, 75% (15) at Level 2, and 5% (1) at Level 3 while for therapeutic hysteroscopy, training participants revealed 20% (4) at Level 1 and 80% (16) at Level 2.

In terms of similarities to real-life anatomy, most participants selected "Agree" or "Strongly Agree." The VR model had a higher proportion of "Strongly Agree" responses (75%) compared to the SAMED model (55%).

Both models positively impacted skills acquisition and user confidence. However, the VR trainer received more Strongly Agree (80%) compared to the SAMED model (60%) in improving training skills and confidence. Among the trainer participants, all trainers preferred the VR model, with 100%

selecting “Strongly Agree” versus 70% “Agree” for the SAMED trainer. They noted superior functionality in the VR model.

Conclusions

Participants found both hysteroscopic modalities helpful in simulation training. However, the VR trainer was favoured, citing it as more realistic and effective than the SAMED model. Trainers also echoed this sentiment, describing the VR platform as user-friendly and highly beneficial for learning hysteroscopy. VR is described to be better than the SAMED model for all trainees and trainers.

Day case hysterectomy -Increasing the confidence and safety net by use of virtual ward

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Background

The national Getting it Right First time report (2021) identified opportunities to reduce the length of stay for women undergoing hysterectomy by utilizing minimally invasive laparoscopic and vaginal surgery, including vNotes .Our centres have been performing day case hysterectomies for benign diseases through an enhanced recovery pathway, having completed over 200 cases of vaginal hysterectomies in the past decade.

Our standard practice includes comprehensive preoperative counselling, a brief postoperative stay, direct access to the gynaecology ward following discharge, and a telephone assessment on the day after the procedure. This system has generally been effective. However, some patients prefer to stay overnight for reassurance. There are instances where clinicians recommend overnight observation for patients with specific conditions, eg-large uterus removed or residing far from the hospital.

Recently, we have integrated virtual ward in our practice. This remote patient monitoring system is designed to provide hospital-level care within a patient's home. Patients track their vital signs using monitoring devices, and this data is transmitted to a clinical team via digital dashboard. The virtual ward facilitates early identification of any deterioration, allowing for timely intervention, reducing hospital admissions and readmissions. This virtual ward model supports earlier discharge, enhances patient well-being, and eases pressure on hospital resources.

We present preliminary findings from the first 10 patients enrolled in the virtual ward following day case hysterectomy, along with feedback from the operating surgeons.

Methods

Patient experience was assessed through a questionnaire on:

- Satisfaction with preoperative information
- Quality of care during the hospital stay
- Experience with virtual ward monitoring and ease of using wearable technology

Surgeons were surveyed regarding:

- Communication with the virtual ward team
- Confidence in discharging patients on the same day

Results

- **Patient Satisfaction:** All patients (100%) expressed satisfaction with the preoperative explanation, hospital care and the virtual ward follow-up. One patient reported difficulty with the technology and uploading data but remained satisfied with the overall experience.
- **Surgeon Feedback:** All operating surgeons reported high satisfaction with the virtual ward communication and felt it provided peace of mind regarding the postoperative well-being of patients.

Conclusions

Although day case hysterectomy is a well-established service, the integration of a virtual ward adds a significant layer of safety and reassurance for both patients and clinicians. The virtual ward model fosters greater confidence in early discharge, offers personalized care, and helps optimize resource use.

Initial results are promising, with high levels of satisfaction reported by both patients and surgeons.

Patients described feeling safe and well-supported at home. The virtual ward was seen as a reassuring safety net, allowing for a smoother transition from hospital to home

However, it is important to address challenges such as technology usability and to ensure equitable access to this model of care for all patients.

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Uterine Arteriovenous Malformation and Pseudoaneurysm Following Robotic Myomectomy

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Background

Introduction Uterine arteriovenous malformations and pseudoaneurysms are uncommon but serious vascular complications that may arise following uterine trauma or surgery. They can present with delayed or profuse bleeding and are often misdiagnosed as more common postoperative sequelae. Robotic-assisted myomectomy, while increasingly utilised, carries potential risks when dealing with large fibroids or breach of the endometrial cavity.

Methods

We report a rare case of combined uterine arteriovenous malformation and pseudoaneurysm formation following robotic myomectomy. A 35-year-old woman presented with persistent bleeding and delayed haemorrhage shortly after surgery for a large posterior intramural fibroid. Imaging revealed active vascular anomalies, and she was managed with selective arterial embolisation. This case highlights the diagnostic complexity and serious nature of vascular complications following minimally invasive uterine surgery. Early imaging and multidisciplinary management are essential. Timely embolisation allowed bleeding control and fertility preservation.

Case Presentation A 35-year-old woman underwent robotic myomectomy for a 10-centimetre posterior intramural fibroid classified as International Federation of Gynaecology and Obstetrics Type 2–5, with intraoperative breach of the endometrial cavity. She was discharged in stable condition but re-presented within 24 hours with vaginal bleeding and clot passage.

Initial ultrasound revealed a uterine haematoma and a suspicious vascular lesion. Conservative management with tranexamic acid and antibiotics was initiated. However, over the following month she experienced persistent bleeding, culminating in hypotension (blood pressure 96/51 mmHg) and a syncopal episode. Triple-phase computed tomography showed active contrast extravasation and a feeding vessel arising from the left internal iliac artery.

Diagnostic angiography confirmed the presence of both a uterine arteriovenous malformation and a pseudoaneurysm. She underwent successful selective arterial embolisation with coil insertion. Post-procedure, her symptoms resolved, and haemoglobin levels stabilised without further transfusion. She was discharged on iron supplementation, tranexamic acid, antibiotics, and a gonadotrophin-releasing hormone analogue (Triptorelin) to support uterine healing. Fertility preservation counselling was provided, with advice to avoid conception for at least three months.

Results

Discussion This case demonstrates a rare but important vascular complication following minimally invasive uterine surgery. Contributing factors likely included the large fibroid size, endometrial breach, and possibly power morcellation. Persistent or delayed bleeding following myomectomy should prompt early vascular imaging. Triple-phase computed tomography and diagnostic

angiography are key to identifying pseudoaneurysms and arteriovenous malformations. Selective embolisation provides a minimally invasive and fertility-sparing solution.

Conclusions

The use of gonadotrophin-releasing hormone analogues post-embolisation may enhance endometrial repair and reduce recurrence risk. Multidisciplinary collaboration between gynaecology, diagnostic imaging, and interventional radiology is essential for timely intervention.

Combined uterine arteriovenous malformation and pseudoaneurysm can occur following robotic myomectomy, particularly with cavity breach. Early diagnosis and selective embolisation can successfully control bleeding and preserve reproductive potential.

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Laparoscopic transabdominal cerclage: A reliable and effective approach in cervical insufficiency

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Background

To evaluate the clinical outcomes and surgical feasibility of laparoscopic transabdominal cerclage (TAC) in patients with cervical insufficiency who experienced recurrent second-trimester pregnancy losses and failed transvaginal cerclage attempts.

Methods

Nineteen patients with a history of cervical trauma, congenital or acquired cervical anomalies, or unsuccessful transvaginal cerclage underwent laparoscopic TAC in our clinic. Surgical technique, postoperative outcomes, and obstetric results were retrospectively evaluated.

Results

Out of 19 patients, 11 delivered healthy neonates via cesarean section between 37 and 39 weeks of gestation. Four pregnancies are ongoing in the third trimester under close monitoring. One patient experienced intrauterine fetal demise at 24 weeks due to a cardiac anomaly. Two patients have not yet undergone embryo transfer, and one failed to conceive despite transfer. No intraoperative complications were reported. The laparoscopic approach provided adequate visualization, secure placement of Mersilene tape, and a favorable recovery profile.

Conclusions

Laparoscopic transabdominal cerclage is a safe, effective, and minimally invasive surgical option for managing cervical insufficiency in selected patients. It improves obstetric outcomes, especially in cases where transvaginal cerclage has failed. Our clinical experience aligns with the growing body of literature supporting laparoscopic TAC as a reliable intervention to reduce preterm birth and enhance neonatal survival.

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Cost Comparison Between GnRHa injection plus Add-back and Relugolix Combination Therapy in the Management of Endometriosis: A 6-Month Predictive Analysis from a UK Gynaecology Service

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Background

Medical therapy plays a central role in managing endometriosis pain and symptoms. The oral GnRH antagonist Relugolix, combined with estradiol and norethisterone acetate (Ryeqo) has recently been included into NICE Guidance as a suitable alternative treatment to conventional injectable GnRHa + HRT. We compared the 6-month cost burden of these treatments.

Methods

In the interest of simplifying cost implications, we compared the cost of GnRHa + HRT with Ryeqo over a 6 month duration. Although the cost of Triptorelin, Leuprorelin, and Goserelin are similar, the negotiated cost implication to our local health service is that Triptorelin is the cheapest and Goserelin most costly. We also considered the cheapest HRT Tibolone and most expensive HRT Evorel Conti Patches negotiated within our health service at the time of analysis. Due to the variation in clinical practice and service delivery structure, we excluded the consideration of appointment and staffing costs (doctors, nurses etc.), prescription charges, and also excluded cost implications to patients like travel, parking, and loss of earnings to attend appointments or in the event of poor efficacy. The assumption is that patients initiated on the medication are satisfied with results and continues for 6 months.

Results

Over 6 months, Ryeqo costs £518.40 (£86.40x6).

Triptorelin and Tibolone costs £385.20 ((3mg £60x6)+(4.20x6)).

Goserelin and Evorel Conti costs £610.24 ((3.6mg £84x6)+(24 patches £53.14x2)).

Conclusions

Additional consultation time should be factored in when discussing availability of the new treatment alternative Ryeqo. In many location, Ryeqo would be considered an Amber Initiation medication, meaning patients initiated on this need an additional consultant appointment to review suitability prior to primary care continuation, where as GnRHa injections often can have a nurse appointment to review on suitability for GP continuation. Meanwhile Ryeqo reduces administrative and prescription complexity for patients and avoids the need for nurse-administered injections. The cost in the analysis considers the burden on the NHS as a whole, but the cost is usually shared between secondary care and primary care when treatment is delivered over 6 months, and different stakeholders may perceive the cost implications differently depending on how much it would cost their employing organisation rather than the NHS as a whole. Within the UK, NHS patients do not pay for the cost of the drugs but take responsibility on prescription charges and the cost of traveling to attend the pharmacy, hospital or GP so the frequency of visits may pose more of a priority when making a decision on their treatment. Looking at the cost of the drugs alone, Ryeqo appears to have

comparable cost implications to the health service. We stress it is important to preserve the availability of choice rather than concluding if one treatment is better than another due to cost alone.

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Outpatient Endometrial Ablation: A retrospective comparison of Paraostial vs. Fundal Anaesthetic Infiltration

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Background

Endometrial ablation (EA) is a therapeutic option for managing heavy menstrual bleeding (HMB) in women who have not responded to pharmacological treatments, have declined such options, or experience severe symptoms (NICE, 2021). This study aims to compare pain scores in fundal block versus paraostial block during outpatient endometrial ablation (OEA), and to assess patient suitability, tolerability, and the overall efficacy of OEA under local anaesthesia.

Methods

A retrospective analysis was conducted over four years (January 2020 to December 2024) on all women who underwent OEA at a single centre. All patients received pre-procedural oral analgesia, a para-cervical block and either fundal or paraostial infiltration of Levobupivacaine using a Williams needle. Pain scores were assessed using a numeric rating scale and compared between the two techniques. Pain scores were also compared to those for outpatient diagnostic hysteroscopy. Additional data collected included patient age, BMI, device activation time, average power used, endometrial coverage, and endometrial biopsy results.

Results

A total of 73 women were included in the study, with 60 patients receiving fundal blocks and 13 receiving paraostial blocks. The demographics of the fundal block group were as follows: mean age of 45 years (range 34-58 years) and mean BMI of 29.9 kg/m² (range 20-50 kg/m²). The mean device activation time in this group was 81 seconds (range 38-120 seconds). The demographics of the paraostial block group were mean age of 45 years (range 27-54 years) and mean BMI of 31.4 kg/m² (range 23-46 kg/m²). The mean device activation time here was 91 seconds (range 45-120 seconds).

The fundal block group reported a mean pain score of 2.7 while the paraostial block group reported a mean pain score of 1.2. The average pain score for OEA in total was 2.4/10, compared to 5.3/10 for diagnostic hysteroscopy.

Conclusions

OEA under local anaesthesia is an effective, well-tolerated, and safe treatment option for women with heavy menstrual bleeding. Although the paraostial group was relatively small and the procedure may present technical challenges, our experience suggests that it offers more effective anaesthesia when successfully performed. We acknowledge the small sample size in the paraostial group as a limitation, and further prospective studies with larger sample sizes and statistical testing are needed to validate these findings.

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Feasibility and Safety of vNOTES Hysterectomy: A retrospective Case Series of 16 Patients

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Background

Introduction: Vaginal Natural Orifice Transluminal Endoscopic Surgery (vNOTES) is an emerging minimally invasive technique for hysterectomy, offering benefits such as reduced postoperative pain, shorter hospital stays, and improved cosmetic outcomes compared to traditional approaches . This study aims to asses the feasibility and safety of vNOTES hysterectomy through a retrospective case series.

Methods

Materials and Methods: Between October 2024 and May 2025, 16 patients undergoing hysterectomy or adnexectomy for benign gynecological conditions were enrolled in this retrospective study at Hospital General de Catalunya. All procedures were performed using the vNOTES approach by experienced surgeons specialized in minimally invasive gynecologic surgery. Data collected included patient demographics, operative time, estimated blood loss, intraoperative and postoperative complications and length of hospital stay and postoperative pain scores.

Results

Results: All 16 vNOTES (15 hysterectomies & 1 bilateral prophylactic adnexectomy) were completed successfully without conversion to laparoscopic or open surgery. The main surgical indication was heavy bleeding in 11 patients (7 of whom had uterine fibroids), and 4 patients with atypical hyperplasia on a polyp, for whom a bilateral salpingo-oophorectomy was also performed. The mean uterine volume was 92.3 x 55.5 mm (range: 122 x 74mm - 73 x 50mm). Eight patients had one or more previous Cesarean sections. The mean operative time was 100 minutes (range: 60' – 130'), and the mean estimated blood loss was 70 mL. Only one intraoperative complication was observed with significant bleeding due to a tear of the paracervical vessels when introducing alexis, with an estimated blood loss of 700 ml. Postoperative complications have not been observed. The average length of hospital stay was less than 24h in 10 patients (62.5%) and less than 48h in 6 patients (37.5%). Postoperative pain score could not be consistently and were therefore excluded from the analysis.

Conclusions

Conclusions: In this preliminary series, vNOTES hysterectomy demonstrated feasibility and safety for the treatment of benign gynecological conditions. The procedure was associated with favorable operative outcomes and minimal complications. These findings support the potential of vNOTES as

an effective minimally invasive alternative for hysterectomy. Further research with larger patient cohorts and longer follow-up is recommended to confirm these results.

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Transvaginal Ultrasound and Laparoscopy-guided Microwave Ablation for Uterine Myoma and Adenomyosis: Preliminary Results

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Background

To evaluate the effectiveness of microwave ablation (MWA) in treating uterine myoma and adenomyosis.

Methods

This prospective study was conducted at Kaohsiung Medical University Hospital from November 2021 to March 2022. A total of 20 patients (13 with uterine myoma and 7 with adenomyosis) underwent transvaginal ultrasound and laparoscopy-guided percutaneous microwave ablation using a 13-gauge antenna and an Emprint Ablation Generator with Thermosphere™ technology. Treatment efficacy was assessed using the Visual Analogue Scale (VAS) for pain, Pictorial Blood Assessment Chart (PBAC) for menstrual bleeding, and Uterine Fibroid Symptom Quality of Life (UFS-QOL) questionnaire at baseline and 1-, 3-, and 6-12 months post-operation.

Results

Significant improvements were observed in VAS and PBAC scores and UFS-QOL scores at 1-, 3-, and 6-months post-operation ($p \leq 0.05$). There was also a considerable reduction in lesion volume with minimal complications, indicating the safety of the procedure.

Conclusions

Transvaginal ultrasound- and laparoscopy-guided MWA is a promising, minimally invasive treatment option for uterine fibroids and adenomyosis. It significantly improves symptoms and quality of life, with a favorable safety profile. This technique presents itself as a viable alternative to traditional surgical methods, particularly for patients wishing to preserve fertility.

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Robot-assisted laparoscopic hysterectomy for gender affirmation: Experience at a tertiary centre

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Background

In the UK, 0.54% of the population identify as transgender representing a significant minority. Management of gender dysphoria includes psychological, medical and/or surgical approaches, with the rates of those seeking treatment increasing over time. While not all patients with gender dysphoria will choose to have gender affirming surgery with a gynaecologist, it is important to be able to adequately counsel this growing population of patients with regards to their particular risk of undergoing surgery.

Methods

A retrospective analysis was performed of patients undergoing robot assisted laparoscopic hysterectomy (RALH) for gender dysphoria at Chelsea and Westminster Hospital since July 2022. An electronic notes review was performed for the 118 patients identified from theatre lists.

Results

All 118 patients were on testosterone therapy. All patients underwent RALH +-ovarian conservation, 19 patients had additional gender affirming surgery (GAS) under the same general anaesthetic.

Mean blood loss was 20mls. In patients exclusively undergoing gynaecological surgery, mean operative time was 79 minutes, 47% were discharged same day and 90% of patients by the end of day 1. No cases were converted to open.

80% patients had a normal pelvic survey at laparoscopy. There were 8 cases of pelvic adhesions, 6 of endometriosis, 5 of adenomyosis and 1 fibroid uterus. The remaining abnormalities included a thrombosed sigmoid epiploica, a thin walled pararectal cyst and an unobstructed umbilical hernia.

Complications noted intraoperatively included 2 vaginal lacerations and 1 iatrogenic burn to the perineum in a patient while undergoing metoidioplasty.

There were 9 postoperative complications excluding those relating directly to metoidioplasty. 7 minor (Clavien-Dindo (CD) 1-2) and 2 major (CD 3-4). The major complications included a return to theatre for bleeding secondary to a vaginal laceration and a small bowel perforation

Conclusions

Overall complication rates were low, with RALH remaining a safe procedure. The CD 4 complication highlights the importance of appropriate patient selection and work up prior to undergoing elective surgery. The patient with small bowel perforation had a significant goitre awaiting surgery. This resulted in a difficult intubation, and distension of the stomach and small bowel so that nasogastric

tube placement on continuous suction was required in order to visualise the pelvis. Injury was likely at entry.

It is also important to consider, the often significant, vulvovaginal atrophy that can occur in patients on testosterone, in particular, while siting the manipulator and removing the specimen, this may be a contributing factor to the complication rates seen in this cohort.

Pelvic pathology was identified in a minority of patients. The incidence of endometriosis seen at laparoscopy was 5%, much lower than the 10% prevalence often quoted, although this did approach 10% (9%) if adenomyosis was included. This reduced incidence may be due to down regulation by hormonal treatment.

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Laparoscopic Excision of Transobturator Tape for Persistent Pelvic Pain and Dyspareunia: A Case Report

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Background

The transobturator tape (TOT) procedure is a widely adopted treatment for female stress urinary incontinence (SUI), offering high success rates and low morbidity. However, complications such as chronic pelvic pain, dyspareunia, and mesh erosion may require surgical intervention. Although rare, complete excision of synthetic mesh may be necessary in cases of persistent symptoms.

Methods

A 50-year-old woman presented to our institution with severe dyspareunia and persistent pelvic pain. The patient reported a history of a TOT procedure performed four months prior. One month after the intervention, the patient was diagnosed with granulation tissue and reported tenderness upon palpation of the skin in the bilateral inguinal fold, as well at the vaginal mucosa along the incision and suture line following the tape placement.

A previous surgical intervention at another facility involved excision of the granulation tissue from both the skin and vaginal areas. However, the patient continued to experience persistent pelvic pain and dyspareunia. Given the ongoing symptoms, a decision had been made to proceed with complete removal of the polypropylene material. To ensure total excision, a laparoscopic approach through the Retzius space was preferred.

Results

Dissection of the Retzius space was carried out, revealing the pubic symphysis. Polypropylene material was identified bilaterally along the urethra, and the tape was dissected up to the obturator muscle. The polypropylene material was completely integrated into the tissue, but it could still be felt with the laparoscopic forceps. The removal of the polypropylene material required deep dissection into the lateral area between the fibers of the obturator muscle. The polypropylene material could not be removed by gentle traction alone; instead, it had to be carefully detached from the surrounding tissue through progressive and gentle dissection until the entire length of the sling, extending under the urethra from one side of the muscle to the other, could be removed. Postoperative recovery was uneventful, and the patient experienced full resolution of pain and dyspareunia.

Conclusions

This case demonstrates that laparoscopic mesh excision is a viable and safe option for treating chronic complications following TOT procedures. Early recognition and a multidisciplinary approach are key to optimizing outcomes in affected patients.

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A Case of Bilateral Ovarian Tumors During Pregnancy Treated with vNOTES

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Background

Transvaginal Natural Orifice Transluminal Endoscopic Surgery (vNOTES) is a minimally invasive technique performed through the vaginal route, which eliminates abdominal incisions and is associated with reduced postoperative pain. Since introducing vNOTES in July 2022, our institution has applied this approach to a range of procedures including hysterectomy, adnexal surgery, myomectomy, and appendectomy. Here, we report a case of ovarian tumor resection via laparoscopically assisted vNOTES during pregnancy.

Methods

The patient was a 33-year-old primigravida with no significant medical history. She was referred to our hospital with a diagnosis of pregnancy complicated by uterine fibroid and bilateral ovarian tumors. At 14 weeks' gestation, pelvic MRI revealed a 6-cm mature cystic teratoma in the right ovary, a 3-cm tumor in the left ovary, and a 6-cm uterine fibroid. Due to the location of the ovarian tumors and the enlarged gravid uterus with fibroid, we anticipated difficulty with a conventional laparoscopic approach.

Results

At 15 weeks and 1 day of gestation, we performed a laparoscopically assisted cystectomy using vNOTES (vLAC). Under general anesthesia, the patient was positioned in lithotomy. The posterior vaginal fornix was incised, and a GelPOINT vPATH port was inserted. Laparoscopic observation revealed the ovarian tumors in the pouch of Douglas. After aspirating the cyst contents, the ovaries were gently drawn into the vaginal canal. Under direct vision, cystectomy was successfully performed. The peritoneal cavity was irrigated, and hemostasis was confirmed. Fetal heartbeat was confirmed immediately postoperatively.

The operative time was 73 minutes with minimal blood loss. The patient experienced mild uterine contractions postoperatively, which resolved spontaneously. She was discharged on postoperative day 2. The remainder of the pregnancy was uneventful, and she delivered vaginally at 40 weeks of gestation with no complications. The postpartum course was also favorable.

Conclusions

In this case, the ovarian tumors were located in the pouch of Douglas, and the presence of a gravid uterus and fibroid rendered the conventional laparoscopic approach challenging. Therefore, vNOTES was considered a safer and more feasible surgical option. This case demonstrates that with appropriate patient selection, vNOTES may be a viable and effective approach for managing ovarian cysts during pregnancy.

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"Pocket-Sign" : a Characteristic Finding of Isthmocele on Hysterosalpingography

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Background

Isthmocele, also known as a cesarean scar defect or niche, has been increasingly recognized as a potential cause of both primary and secondary infertility. Several studies have demonstrated improved pregnancy rates following surgical correction of this defect. Careful evaluation of women presenting with infertility and a prior cesarean section is therefore essential, as overlooking an isthmocele may lead to delayed diagnosis and suboptimal treatment. Although isthmocele is most commonly identified via transvaginal sonography, many women undergoing infertility work-up may initially present with hysterosalpingography (HSG). For this reason, it is of critical importance that clinicians become familiar with the characteristic appearance of isthmocele on HSG to avoid missed diagnosis and to ensure timely management. We aimed to identify and describe a specific hysterosalpingographic pattern—termed the "pocket-sign"—that may serve as a diagnostic clue for isthmocele in women presenting with post-cesarean infertility.

Methods

This retrospective case series included women with secondary infertility and a prior history of at least one cesarean section, who were evaluated between January 2022 and March 2025. All patients underwent hormonal evaluation, semen analysis, transvaginal ultrasonography, and routine HSG as part of their infertility work-up. HSG images were reviewed by two independent observers for contrast pooling in the lower uterine segment during the cavity filling phase. The "pocket-sign" was defined as bilateral symmetrical contrast accumulation adjacent to the isthmic area, creating an image reminiscent of bull horns. The presence of isthmocele was confirmed by transvaginal ultrasound and/or hysteroscopy.

Results

A total of 20 patients presenting with secondary infertility and with suspected isthmocele niche formation in HSG were initially identified. Among these, 12 cases had complete clinical data, including radiological and/or hysteroscopic imaging were included in the analysis. All 12 patients had available hysterosalpingography (HSG) images. In each of these 12 cases, the isthmic accumulation of contrast media-pocket sign-was detected.This specific radiological finding was independently confirmed by two experienced obstetricians and gynecologists in all 12 cases. First 4 HSG images is provided (images 1-4) (figure-1)

Conclusions

In women presenting with secondary infertility and a history of cesarean section, careful attention should be paid during hysterosalpingography to any contrast-filled outpouching near the level of catheter insertion in the lower uterine segment. This widened area may correspond to a uterine niche and could be compatible with our proposed terminology as "**pocket**"

sign." Hysterosalpingography is a two-dimensional imaging technique, which limits the visualization of contrast accumulation in the anterior and posterior uterine walls. As a result, contrast pooling is more commonly observed as lateral expansions on the left and right sides of the lower uterine segment. Therefore, this specific pattern should be carefully considered during image interpretation. Clinicians should remain vigilant when interpreting such findings, as they may reflect an isthmocele and warrant further evaluation.

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Retzius space hematoma after retropubic mid-urethral adjustable sling: how to solve it without removing it.

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Background

The main purpose of this abstract is to help other professionals with patients suffering sling complications.

Methods

A 58-year-old patient consulted in the pelvic floor unit of our hospital for stress urinary incontinence (SUI) 8 years after her first anti-incontinence surgery, a trans-obturator-tape. A pelvic floor ultrasound was performed, showing a flat-flat shape tape, placed in the middle tertium of the urethra, at 10mm of the urethral complex. A second tape was considered in her case, concretely a retropubic mid-urethral sling that ***allows adjustment of the sling, lifetime readjustable if needed.***

The surgery was performed easily under a sedation. A cystoscopy was performed at the end of the surgery to check there were no vesical erosions.

The patient woke up, without pain or other symptoms, with the varitensor device plugged in, in order to adjust the sling the day after the surgery.

Suddenly, 6 hours after the procedure, the patient fainted, claiming pain 8/10 in visual analog scale (VAS) even after intravenous analgesia.

The general exploration of the patient included:

- **no new urine since the end of the surgery.** At the end, 100ml of clear urine was in the catheter bag, the same as when the exploration (6 hours after surgery).
- Abdominal wound dressing was clean.
- Pain at hypogastric region, VAS 8/10, with unconscious abdominal defense.

The complementary exploration of the patient included:

- Abdominal ultrasound ruled out hemoperitoneum. A big hypoechogenic mass in hypogastric region of 65x52x61mm, surrounded by an hyperechogenic structure, was observed. No other findings.
- Pelvic floor ultrasound, showing the vesical catheter correctly placed
- Blood test, pointing a decreased in her hemoglobin from 14 g/dL to 10.4g/dL.

With all the findings, a *Retzius* space hematoma was diagnosed, and the patient underwent surgery again.

The incision was made using the same incision of the varitensor device in the skin (mini-Pfannestiel), but then, the abdominal fascia was opened through a different place in order not to touch the filaments of the device and have the possibility to adjust it after solving the complication.

A huge hematoma was observed surrounding the bladder, contained by the peritoneum of *Retzius* and vesico-vaginal space. The peritoneum was opened and 500 ml of blood clots were drained. No active hemorrhage was observed. A Redon drain catheter was placed in the surroundings of the hematoma.

Intravenous antibiotics and iron were administered.

She had a successful recovery. A week after the surgery, the varitensor was adjusted and removed.

The patient is nowadays without stress urinary incontinence, ICIQ-SF test of 0.

Results

After complications of slings, a conservator treatment could be considered in order to solve the problem of SUI in the patient.

Conclusions

Retzius hematoma after an retropubic mid-urethral adjustable sling can be considered to be drained without removing the device, and therefore successfully treated.

Comparison of Levonorgestrel-Releasing Intrauterine Device and Hysteroscopic Treatment for Abnormal Uterine Bleeding in Cesarean Scar Defects: A Systematic Review and Meta-Analysis

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Background

To compare the clinical effectiveness of the levonorgestrel-releasing intrauterine device (LNG-IUD) versus hysteroscopic resection in the treatment of women with symptomatic cesarean scar defects (CSDs).

Methods

This systematic review and meta-analysis was conducted in accordance with PRISMA guidelines. A thorough literature search was performed across four major databases to identify comparative studies reporting outcomes for LNG-IUD and hysteroscopic approaches in managing symptomatic CSDs. Outcomes of interest included total bleeding days, spotting days, and treatment effectiveness. Data synthesis was performed using a random-effects model, and study quality was assessed with the ROBINS-I and RoB-2 tools.

Results

Three studies, comprising 344 participants, met the inclusion criteria. At 6-month follow-up, LNG-IUD was associated with fewer total bleeding days (mean difference [MD] -4.13; 95% confidence interval [CI]: -5.17 to -3.09; $p < 0.00001$) and reduced spotting days (MD -1.90; 95% CI: -3.37 to -0.43; $p = 0.01$) compared to hysteroscopic treatment. At 12 months, LNG-IUD maintained superior effectiveness (odds ratio [OR] 3.46; 95% CI: 1.53 to 7.80; $p = 0.003$), further reducing total bleeding days (MD -5.69; 95% CI: -6.55 to -4.83; $p < 0.00001$) and spotting days (MD -3.09; 95% CI: -4.69 to -1.49; $p = 0.0002$). Additionally, amenorrhea occurred in approximately half of the LNG-IUD group by one year.

Conclusions

The LNG-IUD appears to be a safe, effective, and less invasive option compared to hysteroscopic surgery for women with symptomatic CSD who are not seeking future fertility. While current data are promising, further well-designed studies are required to confirm long-term outcomes and clarify the role of LNG-IUD in standard treatment protocols.

Use of indocyanine green (ICG) dye at open surgery for sentinel lymph node dissection in gynaecological cancer

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Background

Sentinel lymph node dissection is a key part of surgical treatment for gynaecological cancers and is pivotal in guiding further treatment. Indocyanine green (ICG) fluorescence-guided sentinel lymph node dissection has been the predominant approach at laparoscopic surgery. A laparoscopic camera with an embedded near-field infrared camera makes the use of ICG seamless with no additional camera or processing stack required. For open surgical approaches, use of ICG is not as streamlined. Existing solutions require an additional processing stack and the use of a handheld detector. This occupies one surgical assistant and reduces access and light to the operating field.

We present a new surgical application of ICG, using a small exoscope, similar to a small laparoscopic camera, on a fixed articulating arm, with minimal surgical interference and excellent visualization of pelvic lymph nodes.

Methods

A 44 year old woman with concomitant complex left ovarian and uterine masses was referred to the local Gynaecological Oncology MDT and given the ambiguous origin of the malignancy, a decision was made to perform surgical staging for ovarian cancer and sentinel lymph node biopsy. Two milligrams of 2.5mg/ml ICG was injected into the cervical stroma immediately before prepping the patient. A midline incision was performed and the abdomen was entered routinely. The pelvic sidewalls were opened routinely. Lymphatic tracts and bilateral sentinel lymph nodes were visualised using the Storz Rubina® Lens, excised and sent for histopathology.

Results

The procedure was straightforward, with no complications. The Rubina Lens has a compact profile and minimally interferes with the surgical field. No additional assistant was required. The ICG was visualised very clearly on the screen and was comfortable for the surgeons to consult during the procedure. Two sentinel lymph nodes were identified and excised bilaterally, all of which were benign. The histology revealed synchronous stage 1A endometrioid endometrial cancer and a stage 1A endometrioid ovarian cancer.

Conclusions

ICG can be used at open surgery with good ergonomics and effective results. Advances in laparoscopic surgical techniques can inspire innovation in open surgery, which can be useful in complicated scenarios.

10 years of Laparoscopic Pectopexy: a cohort analysis.

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Background

Pelvic floor defects (PFD) cause a range of symptoms that significantly affect quality of life. Symptom-focused outcomes are now prioritized over anatomical correction to avoid unnecessary reoperations. Long-term data are scarce. For nearly 20 years, our centre has combined native tissue repair (levels 2 and 3) with apical mesh fixation (sacropectopexy/pectopexy). This study reports 4–10-year follow-up outcomes to evaluate the durability and effectiveness of this approach.

Methods

This prospective study was conducted at Rheinlandclinics Dormagen between 2010 and 2019, with approval from the Ethics Committee of the University of Witten/Herdecke (approval no. 173/19). All patients undergoing POP surgery who consented to participate were included. A total of 832 patients who received pectopexy with PRP 3x15 Dynamesh—either as a stand-alone procedure or combined with Level 2 and 3 native tissue repair—were assessed. Clinical data (demographics, history, POP-Q stage, complications, reinterventions) were extracted from medical records. Distinctions were made between recurrent and de-novo prolapse. To evaluate long-term outcomes, patients were contacted via follow-up questionnaires assessing quality of life (QoL) and sexual function (ICIQ-VS, ICIQ Sexual Score, UDI-6 SF, IIQ-7), with 286 responses obtained. Descriptive statistics summarized the data; Mann-Whitney U test and Chi-Square/Fisher's Exact tests were used for group comparisons. Logistic regression was applied to identify predictors of recurrence, complications, and de novo defects. Significance was set at $p < 0.05$ (SPSS v29.0).

Results

Of 832 patients treated with combined native tissue repair and LP, 83.2% experienced no recurrence or new prolapse. Over a 4–10 year follow-up period, 10.2% required additional surgical intervention. Apical prolapse re-fixation was necessary in 5.05% of cases, resulting in an apical cure rate of 94.95%. De novo or recurrent rectocele occurred in 6.8%, and midline cystocele in 9.1%. De novo stress urinary incontinence (SUI) or lateral defects were identified in 3.0%. Recurrences were more common among patients with prior gynecological surgery (32.1%). The mean age was 62.1 years, and the average BMI was 26.5 kg/m². Patient-reported outcomes demonstrated 72.87% symptoms-free and high satisfactory rate. Additionally, 84.53% reported no negative impact on sexual life due to vaginal symptoms, and 86.09% would recommend the procedure to others. UDI-6 SF and IIQ-7 revealed that 56.37% experienced little or no frequent urination, and 59.79% were rarely affected by urgency. Most patients reported minimal urine leakage (71.28%) and no difficulty with bladder emptying (75%), indicating a low overall impact on QoL.

Conclusions

The combination of native tissue repair with LP demonstrates durable and effective outcomes for PFD management, with low recurrence and reintervention rates over long-term follow-up. Patient-reported outcomes confirm high satisfaction and strong recommendation for the procedure. These findings support the approach as a reliable, patient-focused option for pelvic floor repair.

Identification of potential subtype-specific biomarkers in peritoneal, ovarian, and deep endometriosis using RNA sequencing

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Background

To identify subtype-specific biomarkers for endometriosis (peritoneal, ovarian, and deep infiltrating) through transcriptomic profiling of tissue samples, with the aim of supporting the development of non-invasive diagnostic approaches and identifying molecular targets for future subtype-specific therapeutic interventions.

Methods

We conducted an observational study involving 74 participants, including 58 patients with surgically confirmed endometriosis and 16 healthy controls. Tissue samples were obtained from peritoneal, ovarian, and deep infiltrating endometriosis lesions as well as from eutopic endometrium. Unbiased RNA sequencing was performed on patient-derived tissue samples, representing all major subtypes (peritoneal, ovarian, and deep infiltrating). Further gene expression profiles were compared with eutopic endometrial tissue from healthy individuals. Immune cell composition was assessed using computational deconvolution tools.

Results

RNA sequencing revealed significant transcriptional differences between endometriotic lesions and healthy eutopic endometrium, as well as among the three endometriosis subtypes. Notably, phosphodiesterase signaling genes (PDE1A, PDE1B, PDE1C) were strongly upregulated in deep and peritoneal lesions. Secretory phospholipases (PLA2G2A, PLA2G5), known to mediate prostaglandin production and inflammatory signaling, were also markedly increased. Angiopoietin-like 7 (ANGPTL7) was identified as a novel, highly expressed gene in extra-ovarian lesions, with increased protein levels confirmed via ELISA in both deep and peritoneal tissues. Immune profiling revealed increased M2 macrophage polarization and a consistent reduction in natural killer cell abundance across all subtypes.

Conclusions

This study highlights molecular and immunological differences across endometriosis subtypes and identifies several candidate biomarkers with potential diagnostic value. Remarkably, ANGPTL7 emerged as a potential subtype-specific biomarker for extra-ovarian endometriosis. Specifically, ANGPTL7, PLA2G2A, and PLA2G5 may serve as promising targets for the development of non-invasive diagnostic tools and personalized therapeutic strategies in endometriosis. Further validation in larger, independent cohorts is warranted to confirm clinical applicability.

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Best Selected ePoster**

May-Thurner syndrome: A challenging radiographic diagnosis and underlying cause of venous thromboembolism in a post-partum patient

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Background

May-Thurner syndrome (MTS) is an anatomical variant associated with increased risk of venous thromboembolism (VTE). Most commonly, the left common iliac vein is compressed by an overlying right common iliac artery. Compression and pulsations from the overlying artery cause vascular remodelling resulting in impaired venous return and predisposition to deep vein thrombosis (DVT).

Findings in cadaveric studies suggest a 25% background prevalence and an increased risk in women aged 30-50years old. Most cases are asymptomatic, likely due to formation of collateral venous flow over time. Symptoms arise in the presence of additional prothrombotic states such as stasis, infection, pregnancy and the post-partum period.

Acute symptoms include pain and swelling of the affected limb. While chronic complaints are of venous insufficiency such as claudication or venous ulcers. Mortality is usually secondary to consequent pulmonary embolism (PE).

Methods

We report a case of a 28year old P2 woman who presented 12days post ventouse delivery with significant swelling and pain in her left leg and features of systemic infection. An ultrasound doppler confirmed extensive venous thrombus. Laboratory results showed elevated inflammatory markers and high reactive platelets. She was started on therapeutic low molecular weight heparin (LMWH) and broad-spectrum intravenous antibiotics.

A CT abdomen and pelvis was performed to screen for infection. Initial reports were inconclusive and contradictory; changes were seen in the retroperitoneal space and left psoas muscle in keeping with haematoma, inflammatory changes or abscess. Additionally, fluid was seen in the pelvis suggestive of hemoperitoneum or active bleeding. Vascular Surgeons and Haematologists advised that an Inferior Vena Cava (IVC) filter was contra-indicated due to infection and LMWH be held due to active bleeding. She was transferred to the Intensive Care Unit (ICU) for supportive management of her sepsis.

On the fourth day of admission she developed multiple PEs, and an infusion of unfractionated heparin was started.

A Multidisciplinary meeting was held between Obstetrics, Gynaecologists, Haematology, Vascular Surgery, Radiologists and ITU and an MRI Pelvis performed. The MRI ruled out internal bleeding and diagnosed MTS with extensive inflammatory changes and associated thrombophlebitis. No focal collection or retroperitoneal haematoma was seen.

Results

She was discharged after a 13day admission, including 5days in ITU, with therapeutic LMWH and follow up in outpatient anticoagulation clinic.

Conclusions

In the antenatal and postpartum period, (MTS) presents a heightened risk for VTE. While there are no specific UK national guidelines (e.g. NICE or RCOG) for MTS in pregnancy, management is based on general VTE risk assessment principles adapted to this condition. In this case diagnosis and management was challenging due to concurrent infection and inconclusive imaging. Ultrasound and MRI proved the most definitive modalities. MDT care is essential to improve diagnosis, management and outcome for these patients.

Cosmetic Satisfaction Following Robotic Gynecologic Surgery : The Impact of Port Numbers

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Background

As minimally invasive surgery becomes more widespread in gynecology, cosmetic outcomes—especially patient satisfaction with surgical scars—have become an important aspect of postoperative evaluation. Robotic surgery offers the potential for reduced scarring, but the impact of port number on patient satisfaction has not been clearly established.

Methods

This prospective study included 177 patients who underwent robotic gynecologic surgery and were categorized into three groups based on port number: SS (single-site, n = 73), SS+1 (n = 44), and SS+2 (n = 60). All patients provided informed consent and completed a structured questionnaire evaluating cosmetic satisfaction using a visual analog scale (VAS, 0–10). Clinical data—including age, operative time, estimated blood loss, procedure type, hospital stay, and JP drain use—were collected. Group comparisons were performed using ANOVA, chi-square tests, and multiple linear regression. A subgroup analysis between SS+1 and SS+2 was also conducted, including propensity score matching (PSM) to control for age and hospital stay.

Results

Scar satisfaction scores did not significantly differ among the SS, SS+1, and SS+2 groups ($p > 0.8$), despite significant intergroup differences in clinical variables such as age, operative time, blood loss, hospital stay, and JP drain use. Multivariable regression confirmed that port number was not an independent predictor of cosmetic satisfaction; however, age ($\beta = 0.039$, $p = 0.039$) and estimated blood loss ($\beta = 0.0014$, $p = 0.005$) showed significance.

In the subgroup analysis between SS+1 and SS+2, satisfaction scores were 8.64 ± 1.79 and 8.55 ± 1.51 , respectively ($p = 0.7962$), while age differed significantly (39.80 ± 7.03 vs. 42.53 ± 5.38 , $p = 0.034$). After adjusting for age and hospital stay through PSM, SS+1 patients reported significantly higher satisfaction (8.64 ± 1.79 vs. 7.86 ± 1.50 , $p = 0.031$).

Conclusions

The number of robotic ports is not the sole determinant of scar satisfaction. Factors such as patient age and surgical complexity also play important roles. Decisions regarding port number should consider overall surgical complexity and clinical feasibility. Reducing the number of ports, when feasible, may improve cosmetic satisfaction.

Optimizing surgical strategies for endometriosis: correlation of pre-operative serum AMH level with inflammatory and radiologic markers in patients with unilateral endometrioma

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Background

Preserving ovarian reserve is a critical aspect of surgical planning for patients with unilateral endometrioma, though its pre-operative assessment presents challenges. While serum anti-Müllerian hormone (AMH) is a valuable biomarker, its correlation with specific ultrasonography (USG) and magnetic resonance imaging (MRI) features, particularly of the contralateral healthy ovary, warrants further investigation to refine surgical strategies. This study therefore aimed to evaluate the association between AMH levels and various ovarian imaging parameters in women with unilateral endometrioma, seeking to identify reliable indicators for optimizing surgical decision-making and ovarian preservation.

Methods

This retrospective study included 146 women diagnosed with unilateral endometrioma at a single tertiary hospital between 2015 and 2023. Bilateral ovarian sizes were measured using USG and MRI, and various absolute and relative indicators were calculated. Serum AMH levels and inflammatory markers were assessed. Potential correlations between AMH and imaging markers were statistically analyzed.

Results

The mean age and AMH level of the participants were 32.01 ± 5.99 years and 3.54 ± 3.24 ng/mL, respectively. Serum AMH levels showed a significant negative correlation with both age and body mass index (BMI). Among ultrasonographic parameters, only the maximum diameter of the contralateral healthy ovary showed a significant positive correlation with AMH. Similarly, among MRI-derived parameters, the maximum diameter, mean diameter, and volume of the healthy ovary demonstrated significant positive correlations with AMH. Conversely, parameters related to the affected ovary, such as its relative volume, did not show a significant correlation with AMH, strongly suggesting that the functional status of the contralateral healthy ovary is the principal contributor to the patient's overall ovarian reserve.

Conclusions

Imaging-derived parameters of the contralateral healthy ovary significantly correlate with AMH levels in patients with unilateral endometrioma, identifying them as critical pre-operative indicators of ovarian reserve. Incorporating these healthy ovary assessments into surgical planning is essential for tailoring interventions to preserve ovarian function and for guiding evidence-based patient counseling on fertility prospects.

Navigating the Dual Challenge: Laparoscopic Management of Heterotopic Pregnancy

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Background

Heterotopic pregnancy, the simultaneous occurrence of intrauterine and ectopic pregnancies, is a rare condition with an incidence of 1 in 30,000 spontaneous pregnancies (Maleki et al., 2021). The aim of this case report is to explore the successful laparoscopic management of a heterotopic pregnancy, analyse the diagnostic process that led to accurate identification of concurrent intrauterine and ectopic pregnancies, and highlight critical surgical techniques that preserved the intrauterine pregnancy despite significant complications.

Methods

We present a case study of a 32-year-old woman with a past history of conservatively managed ectopic pregnancy who presented with gradual onset of lower abdominal pain. Serial ultrasound examinations, laboratory tests, and laparoscopic surgical intervention were performed. The management approach, surgical techniques, and outcomes were analysed with attention to factors contributing to the successful preservation of the intrauterine pregnancy.

Results

Initial ultrasound revealed an intrauterine pregnancy at 5 weeks' gestation, bilateral corpus luteal cysts, and significant haemoperitoneum. Although the haemoperitoneum was initially attributed to a possible ruptured corpus luteum, follow-up scanning confirmed a heterotopic pregnancy with viable intrauterine pregnancy and right tubal ectopic pregnancy.

Laparoscopic right salpingectomy was performed with meticulous attention to avoiding uterine manipulation. Intraoperative findings included 1000ml of haemoperitoneum and a 2cm right tubal ectopic pregnancy. Surgical technique emphasised careful port placement, minimal handling of the gravid uterus, and precise dissection during salpingectomy.

Post-operative bedside ultrasound confirmed foetal heartbeat, and progesterone support was initiated. Follow-up scan at 9 days post-surgery demonstrated an ongoing viable intrauterine pregnancy with appropriate development for gestational age.

Conclusions

This case demonstrates that heterotopic pregnancy requires high clinical suspicion, especially in patients with risk factors such as previous ectopic pregnancy. The presence of bilateral corpus luteal cysts provided an early indication of potential heterotopic pregnancy that warranted careful monitoring despite initial appearances (Houser et al., 2022).

Laparoscopic management proved safe and effective when performed with appropriate surgical technique, offering excellent visualisation for managing haemoperitoneum while minimising post-operative recovery time. The successful outcome highlights the importance of surgical precision, minimal uterine manipulation, and post-operative hormonal support in preserving intrauterine

pregnancy viability. This case reinforces that laparoscopic intervention, when performed by experienced surgeons with appropriate precautions, represents the optimal approach for managing this rare but potentially life-threatening condition (Zhang et al., 2023).

Transvaginal Sonographic Assessment of the Endometrium and its Histopathological Correlation in Women Presenting with Postmenopausal Bleeding: A Prospective Study

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Background

Postmenopausal bleeding is a common clinical presentation that warrants investigation due to its association with endometrial pathology, including malignancy. This study aimed to identify demographic, clinical, and sonographic predictors of endometrial malignancy in postmenopausal bleeding and to construct a multivariate model to improve risk stratification.

Methods

We conducted a prospective observational study of 165 postmenopausal women presenting with uterine bleeding at University Hospital "Koço Gliozheni" (Tirana, Albania) from December 2023 to January 2025. All patients underwent TVUS evaluation following IETA criteria to characterize endometrial thickness, echogenicity, endometrial-myometrial junction regularity, and Doppler vascularization patterns. Ultrasound findings were correlated with definitive histopathological diagnoses obtained via endometrial sampling. Clinical and demographic data (age, body mass index [BMI], age at menopause, co-morbidities) were recorded. Univariate analysis identified significant risk factors, and a multivariate logistic regression model was developed to determine independent predictors of histologically confirmed endometrial malignancy (significance threshold $p < 0.05$).

Results

Endometrial malignancy was confirmed in a subset of 46 women. Women with malignant pathology were significantly older (age > 64 years), had higher BMI (> 29.6), and experienced later menopause (after age 53) compared to those with benign diagnoses ($p < 0.0001$ for each). TVUS parameters demonstrated strong predictive value for malignancy: an endometrial thickness > 14 mm yielded an area under the ROC curve (AUC) of 0.864, heterogeneous endometrial echogenicity with irregular cystic areas had an AUC of 0.759, and the presence of multiple vessels on Doppler had an AUC of 0.785.

In the multivariate logistic regression, several factors remained independent predictors of endometrial cancer. Older age at menopause was associated with increased risk (OR:1.26 per year; 95% CI:1.01–1.57; $p = 0.04$). Sonographic features of the endometrium were highly prognostic: a heterogeneous echogenicity without cysts conferred an OR of 5.99 (95% CI:1.28–28.03; $p = 0.023$), while a heterogeneous echogenicity with irregular cysts had a markedly higher OR of 14.39 (95% CI:1.42–146.71; $p = 0.024$). An irregular endometrial–myometrial junction was also an independent risk factor (OR 5.75; 95% CI:1.12–29.54; $p = 0.036$). The final multivariable model combining these clinical and ultrasound factors achieved robust discrimination between benign and malignant cases, suggesting high potential for clinical predictive accuracy.

Conclusions

Integrating patient characteristics with detailed ultrasound features meaningfully improves the evaluation of postmenopausal bleeding. This study highlights that certain TVUS findings—especially a heterogeneous endometrial echo with irregular cystic changes and an irregular endometrial border—are strong indicators of underlying endometrial carcinoma. Women presenting with these high-risk ultrasound features (in conjunction with risk factors such as late menopause and elevated BMI) should be prioritized for prompt invasive diagnostic procedures, as our combined ultrasound-histopathology model enhances risk stratification and diagnostic accuracy. Adopting standardized IETA ultrasound criteria in clinical practice can thus aid in early identification of endometrial malignancies and guide more effective management of postmenopausal bleeding.

A rare case of rectovaginal fistula caused by idiopathic tuberculosis after vNOTES hysterectomy

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Background

A **fistula** is an abnormal passage between two surfaces lined with epithelium A **rectovaginal fistula** refers to an atypical connection between the **rectum** and **vagina**. The most common causes of rectovaginal fistula include **previous surgeries**, **infections**, and **inflammatory bowel diseases** and electrocoaterizations

This report describes a rare case of rectovaginal fistula caused by idiopathic tuberculosis after vNOTES hysterectomy

Methods

The patient was a healthy 52-year-old woman applied to our clinic with postmenopausal bleeding. In the ultrasound image the endometrium was observed as 12 mm cystic and irregular. Her endometrial pathology was hyperplasia without atypia. She underwent a vNOTES hysterectomy and bilateral salpingo-oophorectomy for postmenopausal bleeding. Pathology result was evaluated as endometrioid intraepithelial neoplasia and benign tubes and ovaries. The patient was discharged with dual antibiotics after gas and stool discharge on the first postoperative day. The patient applied to our hospital with a complaint of stool discharge from the vagina on the 17th postoperative day. It was learned that she did not use her antibiotics. Fecal contamination was observed in the vaginal examination. She was admitted for further follow-up and intravenous antibiotics. Contrast imaging was performed after the general surgery opinion was obtained during the patient's follow-up. No fistula tract was observed. Colonoscopy was performed due to the persistence of fecal contamination. A suspicious fistula area was observed at the level of the rectum 15th cm and she was referred to a tertiary hospital. Irregular fibrotic changes were observed in the computerized tomography taken due to the decrease in saturation during the service follow-up and its continuation. The pulmoner medicine department did not consider additional pathology. Diagnostic laparoscopy was decided due to the persistence of fecal contamination. Widespread miliary tuberculosis foci were observed in the abdominal imaging. Biopsy was performed. A colostomy was opened due to widespread intra-abdominal tuberculosis foci and adhesions. Pathology result was reported as granulomatous lesions compatible with tuberculosis. Then, a ppd test and tuberculosis-related tests were performed. It was not evaluated as active tuberculosis. During intensive care follow-up, tuberculosis treatment was started due to the progression of the patient's acute condition to septic status. After treatment, the patient's general condition stabilized and her colostomy was closed in the first year. There was no vaginal fecal contamination. She has no additional complaints in his 2 year follow-up.

Results

Rectovaginal fistula is an uncommon complication that may arise following gynecological surgery, with an estimated repair rate of 0.6 per 100,000 women. This condition can lead to distressing symptoms, including the passage of gas, fecal matter or discharge through the vagina significantly affecting a patient's quality of life.

Conclusions

Rectovaginal fistulas are usually surgical in origin, but they can also occur due to infection, as in this case. In such cases, the best results can be achieved with a team approach. A good working partnership between colorectal surgeons and gynecologists can significantly increase patient's safety and well being.

vNOTES Sentinel Lymph Node Biopsy in Endometrial Cancer Patients with a BMI Exceeding 30 kg/m²: Perspectives from the Turkish Minimally Invasive Gynecologic Surgery Platform (TR-MIGS)

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Background

Recent studies increasingly report the successful use of the vNOTES technique for surgical staging in patients with endometrial cancer. Given that a significant proportion of these patients are obese or morbidly obese, surgical staging in this group poses distinct challenges. These individuals frequently have a higher incidence of comorbid conditions, face elevated anesthesia-related risks, and present heightened surgical difficulties. Obesity is associated with an increased likelihood of complications such as wound infections and venous thrombophlebitis, as well as extended hospital stays. This research focuses on assessing the feasibility and surgical outcomes of utilizing vNOTES retroperitoneal dissection and sentinel lymph node (SLN) mapping specifically in obese and morbidly obese patients with endometrial cancer.

Methods

Pathohistological examination confirmed Grade I or II endometrioid endometrial adenocarcinoma in all patients. PET-CT scans were utilized at the clinician's discretion to exclude extrauterine disease. All patients underwent pelvic lymphadenectomy combined with sentinel lymph node (SLN) mapping. Indocyanine green (ICG)-based near-infrared fluorescence imaging was used in 11 cases, while methylene blue dye was employed in 19 cases. These procedures were followed by a hysterectomy and adnexectomy performed using vNOTES. Retroperitoneal vNOTES SLN mapping was performed following the Memorial Sloan Kettering Cancer Center protocol.

Results

This study involved 30 patients with a mean age of 57.3±9.7 years. The average BMI was noted to be 35.8±5.8 kg/m². Patients had an average of 3.6±1.4 SLNs removed, ranging between 1 and 7 nodes. The overall detection rate of SLNs was 86.6%, with unilateral detection observed in 13.3% of cases and bilateral detection in 73.3%. Lymphatic metastases were present in 1 patients (3%). SLN removal without additional lymphadenectomy was carried out in 21 patients (70.0%), while 8 patients (26.7%) underwent bilateral pelvic lymphadenectomy, and 1 patient (3.3%) underwent both bilateral pelvic and para-aortic lymphadenectomy. The majority of SLNs were identified in the obturator area

(62.1%), followed by the internal iliac region (27.3%) and, external iliac region (10.3 %). No complications occurred during surgery or the postoperative period, and the average hospital stay was 2 days.

Conclusions

vNOTES serves as an effective alternative for retroperitoneal sentinel lymph node isolation, offering particular advantages for obese and morbidly obese individuals. A major benefit is the reduced time patients spend in the Trendelenburg position during the procedure. This improvement not only increases the practicality of the method but may also lower the risk of needing to convert the procedure due to respiratory challenges caused by prolonged positioning. To further validate the role of vNOTES in the treatment of endometrial cancer, well-designed prospective studies or randomized controlled trials involving larger patient groups are crucial.

TR-MIGS SLN Group: Kemal GUNGORDUK, Selcuk ERKILINC, Vakkas KORKMAZ, Candost HANEDAN, Salih TASKIN, Kemal OZERKAN, Cagatay TASKIRAN

Novel biodegradable scaffolds for Full-thickness cervix reconstruction

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Background

Congenital deficiency or extensive cervical injury leads to female genital tract obstruction and cervical laxity, resulting in infertility or miscarriage. The capacity of current surgeries to support the regeneration of each histological structure and function of the cervix remains uncertain. In this study, we fabricate novel scaffolds to regenerate full-thickness cervix including both epithelial and stromal layer and provide new treatments for cervical deficiencies and injuries.

Methods

Based on cell-type-specific properties, we fabricated a novel double-layered collagen membrane (CM) scaffold from decellularized bladder extracellular matrix. This scaffold features a relatively dense, non-porous 'smooth layer' and a relatively loose, porous 'rough layer'. Each layer was adapted to support the growth of epithelial cells and stromal cells, respectively. Further, the thickness and folded 'sandwich' structure were tailored to match the cervical structure. SEM was applied to observe the surface structures. Mechanical property was assessed using a tensile machine. Epithelial cells and fibroblast were cultured and seeded into the different layer of scaffold to evaluate the biocompatibility. Rabbit full-thickness and total ectocervix excision models were established to investigate the regeneration capacity. After 3 and 6 months, H&E staining and Masson's trichrome was performed to detect tissue morphology. Periodic-Acid-Shiff (PAS) staining and Alcian-Blue staining were performed to evaluate the expression of neutral mucins and acidic mucins respectively. α -SMA, CD31, and Cytokeratin 19 immunostaining were performed to evaluate the expression of smooth muscle, vascular and epithelial cells. The mechanical property of neo-cervix was also assessed.

Results

Only CM scaffold groups enabled the regeneration of neo-ectocervix tissue, including epithelium, stroma and muscular layers after 3 and 6 months. The neo-ectocervix regenerated by CM scaffolds exhibited significantly higher expression of secretory glands and estrogen receptors, more secretion of neutral and acidic mucins, showing functional maturity of regenerated epithelium. Notably, CM scaffolds supported the regeneration of stroma and muscular layers. The mechanical strength of neo ectocervix was comparable to that of normal ectocervix.

Conclusions

CM scaffolds demonstrate good biocompatibility, support different cell growth, and enhance superior regeneration of epithelium, stromal and muscular tissue of the cervix, confirming its construction capacity as new strategies for addressing cervical deficiency and damage.

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Best Selected ePoster

Preoperative clinical and sonographic determinants of intraoperative blood loss in laparotomic myomectomy: a secondary analysis of a prospective observational study

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Background

Uterine smooth muscle tumors are a heterogeneous group of mesenchymal neoplasms with multiple histologic variants and distinct biological behaviors. Pathologic classification as benign, malignant or tumor with uncertain malignant potential depends on the mitotic index, presence/absence of tumor cell necrosis, and degree of cytologic atypia. Benign variants may mimic malignancy. Uterine fibroids affect up to 80% of women, with 50% prevalence in reproductive age. Uterine mesenchymal malignancies account for 3–7%. Symptoms include menorrhagia/metrorrhagia, pelvic pain, dysmenorrhea, “bulky” symptoms, adverse obstetrical outcome (miscarriage). Ultrasound is the first-line imaging technique for uterine pathology. The 2015 MUSA consensus standardized the sonographic assessment of myometrial lesions. Our group recently developed a 3-class ultrasound-based algorithm (Mylunar study) for preoperative risk stratification. This study aims to evaluate baseline clinical and ultrasound parameters of women undergoing laparotomic myomectomy in relation to the intraoperative blood loss (EBL), with the aim of identifying preoperative factors that could inform hemorrhagic risk stratification and surgical planning.

Methods

This is a secondary analysis of a prospective single-center observational study. Data were collected from 422 patients who underwent elective laparotomic myomectomy at a tertiary university hospital between January 2019 and January 2023. Preoperative ultrasound evaluation was performed by experienced gynecologist using standardized MUSA terminology and FIGO classification system for fibroid mapping. EBL was estimated through suction volume and sponge weigh; patients were categorized into three groups: <250 mL, 250–500 mL, and >500 mL. Clinical data, including age, BMI, symptoms, and hemoglobin levels, were collected. To limit confounding related to surgical complexity, a subgroup analysis was performed on 152 patients undergoing single myomectomy. All surgeries were performed by gynecologic surgeons with over 5 years of experience. Associations between clinical/sonographic variables and blood loss were analyzed using Kruskal-Wallis and chi-square tests.

Results

Patients with EBL>500 mL had significantly higher BMI (median: 24.3 kg/m² vs. 22.0 kg/m²; p=0.004), larger dominant fibroid diameters (median: 95 mm vs. 74 mm; p<0.001). Fibroids with intramural component (FIGO types 2–5) were significantly associated with increased blood loss (p = 0.006). Visualization of normal surrounding myometrium was less frequent in cases with high EBL (86% vs. 95.3%, p=0.010), possibly reflecting increased vascularity or deeper localization. Other MUSA features—vascular pattern, margin regularity, cystic areas, "cooked-aspect", shadowing—had no significant correlation with hemorrhage. Subjective suspicion of malignancy on ultrasound was not predictive of EBL. Not unexpectedly, the number of fibroids removed correlated with blood loss (p<0.001). For this reason, we proceed with the subanalysis of data from patient who had undergone single myomectomies. In this subgroup, trends between EBL and BMI, fibroid size, and FIGO classification were confirmed, but did not reach statistical significance. Regardless of the surgical approach, postoperative hemoglobin levels were significantly lower in patients with higher EBL (p<0.001).

Conclusions

In patients undergoing open myomectomy, high BMI, large fibroid size, intramural site, and multiple fibroids are associated with increased intraoperative blood loss. While some ultrasound features were not related to this complication, preoperative assessment of fibroid size, FIGO type, and surrounding myometrium visualization can help in stratifying the risk of bleeding. These findings may improve preoperative risk assessment, counselling to patients and support the development of ultrasound-based algorithms to optimize surgical planning and perioperative care. Future prospective multicenter studies are needed to validate these predictors on larger scale.

Which approach is safer? Robotic-assisted vs. Laparoscopic Surgery in the management of morbidly obese patients with endometrial cancer

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Background

The rising prevalence of obesity presents a growing challenge in the surgical management of gynecologic malignancies. Endometrial cancer is strongly associated with excess body weight, and morbidly obese patients (BMI ≥ 40 kg/m²) are at increased risk of perioperative complications, why surgical approach is critically important.

The comparison of the effectiveness of robotic-assisted surgery and laparoscopic procedures continues to be the a burning topic of ongoing research and debate. In addition to increasing surgical precision and improving visualization, robotic-assisted procedures also allow for complex maneuvers which can be challenging in laparoscopy, making it particularly advantageous in oncological surgery, especially in cases of morbid obesity, where margins of error can significantly influence the outcome of the disease.

Methods

Two subgroups were compared who had definitive surgery due to early stage of endometrial cancer at the Department of Obstetrics and Gynecology, University of Debrecen: patients who underwent surgery using robotic-assisted techniques between April 2024 and May 2025 and who had conventional laparoscopy between January 2023 and May 2025. Using statistical tests, we examined the rate of intraoperative and postoperative complications, length of hospital stay, surgical time, and the rate of conversion to open surgery.

Results

In nearly 60% of the 70 selected patients, definitive surgery was performed using robotic-assisted techniques (RA subgroup), while the remaining part of the patients underwent laparoscopic surgery (LSC subgroup), from all of the surgeries 97% was successfully completed. In the LSC subgroup, the rate of intraoperative and postoperative complications was $>5\%$, but in the RA subgroup, we did not observe any intraoperative or postoperative complications. Intraoperative blood loss and hospital stay were significantly lower in the RA subgroup, although surgical time was longer.

Conclusions

Minimally invasive surgery methods, such as conventional laparoscopy and robotic-assisted surgery, offer significant benefits over open surgeries, including reduced blood loss, shorter hospital stay, and fewer postoperative complications. However, the optimal minimally invasive strategy in this high-risk population remains a matter of ongoing debate. This study aims to compare the safety and efficacy of robotic-assisted versus traditional laparoscopic surgery in morbidly obese women undergoing surgical treatment for endometrial cancer. The advantages of robotic-assisted method are particularly significant in patients with high BMI, where anatomical and technical challenges are more pronounced. As obesity rates continue to rise globally, robotic-assisted surgery may represent the preferred minimally invasive option for this growing high-risk population.

Cervical Cancer Screening in Rural Kazakhstan: Barriers to Access and Implications for Early Diagnosis

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Background

To evaluate patient satisfaction and identify access barriers in cervical cancer screening among rural women in the Almaty region of Kazakhstan, with implications for early detection and intervention.

Methods

A cross-sectional sociological study was conducted involving 819 women aged 30–70, selected via random sampling across primary healthcare units and a multidisciplinary clinic. Two separate questionnaires (407 and 412 responses) were used. Exclusion criterion: being under oncologic follow-up. Statistical analysis was performed using SPSS 8.0. Student's t-test was applied, with significance set at $p < 0.05$.

Results

Screening coverage among eligible women declined from 92.9% in 2021 to 54.9% in 2023. Among rural respondents, 59.1% reported lack of time as the primary barrier, while 16.8% were unaware of the disease. Although 71.9% had symptoms, they did not seek care. Awareness of HPV vaccination was low (18.7%). Only 39.1% had ever undergone cervical screening, and among them, 93.8% rated the quality as "excellent" or "good." However, delays in receiving results were cited as a key concern. Most women (87.3%) preferred receiving screening outcomes directly from a physician. Informational gaps were evident: over 50% were unaware of cervical cancer symptoms, and nearly 93% did not use barrier contraception. Despite these gaps, satisfaction with service courtesy and attention was high.

Conclusions

This study reveals that despite high satisfaction with the quality of care, significant systemic and informational barriers hinder effective cervical cancer screening in rural Kazakhstan. These include time constraints, poor awareness, delayed result communication, and low vaccination literacy. Improving program effectiveness requires the following: - Better education and outreach initiatives; - Clear and timely communication of test results; - Empowerment of primary care providers through oncology-focused training; - Integration of mobile or digital communication for result delivery in remote regions. These findings underscore the importance of addressing logistical and educational gaps to increase early detection of pre-cancerous lesions. Strengthening the cervical screening program will enable earlier, potentially less invasive surgical management of cervical pathology.

The Role of Hysteroscopy in Diagnosing Endometrial Thickening in Postmenopausal Bleeding

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Background

Postmenopausal bleeding (PMB) is one of the alarming symptoms in clinical practice and may, in some cases, be an early sign of malignant tumors of the endometrium. PMB is defined as any vaginal bleeding occurring 12–24 months after the onset of amenorrhea following menopause. According to various studies, endometrial cancer is diagnosed in approximately 10% of women with PMB. If transvaginal ultrasound (TVUS) reveals an endometrial thickness greater than 5 mm in postmenopausal women, further diagnostic investigations are considered essential. In this context, hysteroscopy emerges as one of the most effective and minimally invasive diagnostic tools. It not only provides visual assessment but also allows for targeted biopsy and, in some cases, simultaneous therapeutic intervention.

Methods

The study analyzed data from 70 women aged 50–75 in the postmenopausal period who presented with complaints of vaginal bleeding at the Oncology Clinic of Azerbaijan Medical University. Transvaginal ultrasound revealed an endometrial thickness greater than 5 mm in all cases. All patients underwent diagnostic hysteroscopy; the uterine cavity was visually examined, and targeted biopsies were taken from suspicious areas.

Results

Hysteroscopy provided a clear visualization of endometrial structure. Among the patients, 28 had atrophic endometrium, 21 had endometrial polyps, 10 had non-atypical hyperplasia, 7 had atypical hyperplasia, and 4 were diagnosed with early-stage endometrial cancer. The sensitivity of hysteroscopy was 97%, specificity 98.6%, positive predictive value 95%, and negative predictive value 99%. Therapeutic procedures were performed during the same session in 28 patients with benign lesions (such as polyps and hyperplasia), thus avoiding repeat operations and hospitalization. The diagnostic accuracy of hysteroscopy was high; sensitivity and specificity values were consistent with other studies. The sensitivity and specificity of hysteroscopy in detecting endometrial cancer were reported to be 76% and 94.1%, respectively. The positive predictive value in diagnosing endometrial hyperplasia was 63%.

Endometrial cancer was found in 8.81% of women with endometrial thickness <5 mm and in 30.88% of women with ≥5 mm thickness. This difference was statistically significant ($p = 0.0133$). Histopathological examinations showed that 23.53% of participants had endometrial cancer, 8.82% had hyperplasia, and 41.18% had polyps.

Conclusions

Hysteroscopy is a highly diagnostic, safe, and effective method for assessing endometrial thickening associated with postmenopausal bleeding. Its dual diagnostic and therapeutic application makes it the first-choice procedure for this patient group. The findings indicate that hysteroscopy plays a crucial role in the early detection of oncological processes and helps avoid unnecessary surgical

interventions. It holds significant diagnostic value in identifying the causes of endometrial thickening during postmenopausal bleeding. Its diagnostic accuracy approaches nearly 100%, and it also enables therapeutic intervention during the same procedure.

Evaluating the Learning Curve in Robotic Total Hysterectomy: A Comparison Between Single-Port and Multiport Da Vinci Platforms

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Background

To assess and compare the learning curves of the Da Vinci S (multiport) and Da Vinci SP (single-port) for total hysterectomy.

Methods

This is a retrospective comparative study on patients undergoing robotic total hysterectomy (benign or early endometrial cancer indication) with the Da Vinci S Multiport (MP) and Single-Port (SP) systems. All operations were performed by the same surgeon, and cases performed with the SP system were performed after the MP system. Operating time was used as the main indicator of the learning curve, analyzed by the CUSUM method. Data were processed with R software, and differences between groups were evaluated with t-test (significance $p < 0.05$).

Results

The study analyzed 73 patients who underwent da MP hysterectomy and 74 who underwent Single-Port SP hysterectomy. Both groups had similar surgical indications and comparable demographics, including mean age (58 MP vs. 63 SP) and BMI (31 MP vs. 29 SP). Operative times were not significantly different (117 min MP vs. 114 min SP, $p > 0.05$). However, the SP group had a significantly lower postoperative hemoglobin drop (1.18 vs. 2.07 g/dL, $p < 0.05$). All surgeries were performed by the same surgeon. A clear learning curve was observed: the MP group showed a steeper improvement (-0.3 min/case) compared to a flatter curve in the SP group (-0.009 min/case), as shown in Figure 1. CUSUM analysis revealed a three-phase pattern for both, with mastery reached after 50 MP and 13 SP cases (Figure 2).

Conclusions

The SP system demonstrated a shorter learning trajectory, reaching mastery after 13 procedures, compared to 50 with the MP system. This accelerated progression reflects positive skill transfer; once surgeons internalize core robotic skills, such as camera control and wrist articulation, only platform-specific adjustments need to be learned. A major strength of the study is its unique comparative focus and procedural consistency, as all surgeries were performed by a surgeon with many years of experience in laparoscopic surgery (E.V.). However, this limits generalizability. The study concludes that prior MP experience enhances SP learning, but broader validation with diverse surgeon profiles is needed.

Efficacy and safety of robotic surgery compared to laparoscopic surgery for interval debulking operation in advanced ovarian cancer

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Background

Neoadjuvant chemotherapy (NACT) followed by interval debulking surgery (IDS) has become the standard treatment for selected patients with advanced ovarian cancer (AOC). While laparoscopic surgery has been used for minimally invasive IDS, the role of robotic surgery using the DaVinci-SP system remains under evaluation. This study aims to compare the perioperative outcomes, oncologic efficacy, and safety of robotic surgery (RS) versus laparoscopic surgery (LS) in IDS for AOC patients.

Methods

A retrospective study was conducted, including patients diagnosed with stage III-IV ovarian cancer who underwent NACT followed by IDS via either RS (8 cases) or LS (11 cases) from 2021 August to 2025 January in our institution. Perioperative outcomes such as operative time, estimated blood loss, length of hospital stay, and intraoperative complications were analyzed. Additionally, the rate of optimal cytoreduction (residual tumor < 1 cm) were compared between the two groups.

Results

RS demonstrated a disadvantage in terms of longer operative time, however, did not show the difference of blood loss and length of hospital stay compared to LS. The complication rates were also similar between the two approaches. Preliminary analysis suggests that RS is associated with comparable rates of optimal cytoreduction to LS. Long-term oncologic outcomes, including PFS and OS, are under further investigation to determine the impact of robotic IDS on survival.

Conclusions

Robotic IDS using the DaVinci-SP system appears to be a feasible and safe alternative to laparoscopic IDS after NACT for AOC. Further studies are required to validate robotic surgery's oncologic efficacy and cost-effectiveness compared to laparoscopic approaches.

The Impact of Hysteroscopic Surgery on the Success Rates of Frozen Embryo Transfer in Women with Initial Fresh Embryo Transfer Failure

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Background

Aim: This study evaluates the outcomes of frozen embryo transfers (FET) in women with infertility who experienced initial failures after fresh embryo transfers, focusing on the role of hysteroscopic surgery in success rates.

Background: Infertility remains a global challenge, and despite advancements in assisted reproductive technologies, many women encounter unsuccessful fresh embryo transfers. Hysteroscopy is crucial for diagnosing and treating intrauterine abnormalities that may compromise implantation success.

Methods

Methods: A cohort of 353 women who underwent IVF treatments from 2021 to 2023 was analyzed. Participants were categorized into two groups based on hysteroscopic findings: Group A (normal results) and Group B (findings of endometrial polyps or chronic endometritis (CE)).

Results

Results: After undergoing hysteroscopic evaluations, all patients received appropriate treatments for identified conditions. The outcomes of subsequent frozen embryo transfers were assessed by measuring implantation rates, clinical pregnancy rates, and live birth rates.

- **Group A (Normal Hysteroscopic Results):** The implantation rate was 49 %, clinical pregnancy rate 66%, and live birth rate 58 %.
- **Group B (Polyps/Inflammation Treated):** Following treatment, the implantation rate was 46%, clinical pregnancy rate increased to 65 %, and live birth rate rose to 55%.

Statistical analysis indicated no significant differences in pregnancy rates between the two groups.

Conclusions

Conclusion: Hysteroscopic surgery plays a vital role in improving the success rates of frozen embryo transfers for women who have experienced unsuccessful fresh embryo transfers. By focusing on uterine health, healthcare providers can enhance fertility outcomes for patients facing challenges in their reproductive journeys.

Impact on Patients' Health: Addressing intrauterine abnormalities through hysteroscopic surgery not only improves the chances of successful pregnancies but also contributes to the overall well-being of patients. Women experiencing infertility often face emotional stress and psychological challenges. By enhancing reproductive success rates, hysteroscopic intervention can alleviate some of this

psychological burden, providing hope and improving quality of life for patients on their path to parenthood.

Fertility-preserving laparoscopic management of intramural pregnancy with hemoperitoneum in the first trimester: A case report

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Background

Intramural pregnancy is an extremely rare and life-threatening form of ectopic pregnancy, accounting for less than 1% of all ectopic cases (Ko et al., 2006). It is characterized by implantation of the gestational sac within the myometrium, typically without communication with the endometrial cavity or fallopian tubes. Early diagnosis is challenging due to non-specific clinical symptoms but is critical to prevent severe complications such as uterine rupture and hemorrhage. Intramural pregnancies are frequently associated with prior uterine surgeries (e.g., curettage, myomectomy) or assisted reproductive techniques, which emphasizes their clinical relevance.

Methods

We report the case of a 33-year-old woman, gravida IV para I, at 9+6 weeks of gestation, who was referred to our unit with sudden, severe abdominal pain. Her obstetric history included one curettage for missed abortion and a second curettage for retained placental tissue. Transvaginal ultrasound revealed a live gestation embedded entirely within the myometrium of the uterine fundus and a substantial haemoperitoneum—findings diagnostic of an intramural ectopic pregnancy (Figures 1 and 2). Due to the patient's haemodynamic instability, an emergency laparoscopic procedure was performed. The patient underwent complete excision of the gestational cavity, right salpingectomy, and multilayer uterine reconstruction to preserve future fertility.



Figure A: Transvaginal sonography showing an intramural ectopic pregnancy in the uterine fundus accompanied by free intraperitoneal fluid indicative of haemoperitoneum.

Figure B and C: Intraoperative image of the firmly adherent, oedematous tube and suture reconstruction of the uterus after complete removal of the pregnancy tissue.

Results

Intraoperatively, a clearly oedematous right tube was found, which was firmly adhered to the uterus. Below the tube, an intact intramural pregnancy extended to the uterine cavity; in addition, there was a pronounced haemoperitoneum. The procedure was completed without complications, and both the intraoperative and postoperative courses were uneventful. A blood transfusion was not necessary. The lowest haemoglobin level postoperatively was 7.7 g/dl. The patient was discharged on postoperative day 3. Histopathology confirmed intramural pregnancy. Serial β -hCG monitoring showed a rapid decline. Contraception was recommended for at least 6 months. Remarkably, the patient conceived spontaneously following recovery, with a planned caesarean section in June 2025.

Conclusions

Intramural pregnancy requires a high diagnostic vigilance, especially in patients with a history of uterine surgery or assisted reproduction. Early laparoscopic management can safely preserve fertility even in emergent cases. This case not only underscores the importance of timely diagnosis and individualized surgical care, but also demonstrates the potential for successful spontaneous conception after conservative surgical treatment—an outcome that highlights the efficacy of the chosen approach.

References:

Ko, H., Lee, Y., Lee, H., Park, I., Chung, D., Kim, S., Park, T., & Shin, J. (2006). Sonographic and MR findings in 2 cases of intramural pregnancy treated conservatively. *Journal of Clinical Ultrasound*, 34(7), 356–360. <https://doi.org/10.1002/jcu.20245>

<https://esge.covr.be/cmdocumentmanagement/conferencemanager/documents/api/getdocument/14582/cmabstsms/0000203660/b68fd4bb688baed9e9b0e566018c2c619a58d31b8e1e9c7c1f55e0cd0af0d31d>

Evaluation of ovarian reserve after robotic single-site ovarian cystectomy using anti-Müllerian hormone levels compared to historical laparoscopic cohorts

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Background

Serum anti-müllerian hormone (AMH) is regarded as a useful marker in predicting for ovarian functional reserve. The aim of this study was to investigate the impact on the ovarian reserve after robotic single-site ovarian cystectomy.

Methods

About 130 patients who underwent robotic single-site ovarian cystectomy for benign ovarian tumor from 2020 to 2024 were analyzed retrospectively. The AMH levels were measured by enzyme immunoassay preoperatively and at 6 or 9 months after surgery. The difference and ratio of AMH levels were compared to the historical laparoscopic cohorts from published studies.

Results

The AMH levels were decreased at 6 or 9 months after surgery in all patients 9 (ratio of AMH levels between preoperative and 6 or 9 months, 0.53 ± 0.22 ng/mL). Considering age, total operation time, tumor histology, tumor size, and tumor bilaterality, both preoperative basal and postoperative AMH levels in bilateral endometrioma group were significantly lower than the unilateral endometrioma group ($p = 0.022$ and $p < 0.001$, respectively). In addition, the decrease of AMH level after surgery in bilateral endometrioma in this study was less compared to the historical laparoscopic cohorts.

Conclusions

Robotic single-site ovarian cystectomy could be considered for preserving ovarian function in patients with bilateral ovarian endometrioma.

Anti-Müllerian hormone level does not predict complete regression verified by follow-up hysteroscopy in fertility-sparing management of endometrial cancer and endometrial intraepithelial neoplasia

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Background

Recent studies have suggested that Anti-Müllerian hormone (AMH) may act as a tumour suppressor by inhibiting the growth of AMH receptor-expressing endometrial cancer cells. Based on this potential role, this study aimed to evaluate whether serum AMH levels could serve as a predictive biomarker for treatment outcomes in patients with endometrial cancer or endometrial intraepithelial neoplasia (EIN) undergoing fertility-sparing treatment (FST).

Methods

: A retrospective review was conducted on 100 patients diagnosed with endometrial cancer or EIN who received progestin-based FST between 2010 and 2024 at a single institution. Serum AMH levels measured within one year before or after the initiation of hormonal therapy were collected for analysis. Specifically, the study investigated whether AMH levels were associated with complete regression (CR) rates and the time to achieve CR.

Results

A total of 100 patients were included in the analysis. The mean age of the patients was 35.7 ± 4.7 years, and the mean BMI was 25.7 ± 6.1 kg/m². Among the 100 patients, 64 were diagnosed with EIN, 34 with FIGO grade 1 endometrial cancer, and 2 with FIGO grade 2. The most common treatment regimen was medroxyprogesterone acetate (MPA) combined with levonorgestrel-releasing intrauterine system (LNG-IUS) (39.0%), followed by LNG-IUS alone (32.0%) and MPA alone (22.0%). During a mean follow-up period of 30.9 ± 22.1 months, 59 (59%) of patients achieved CR. The average time to CR was 12.6 ± 7.4 months. In univariate and multivariate logistic regression analyses, only BMI was significantly associated with CR success (OR = 0.91, 95% CI: 0.84–0.99, $p = 0.033$). Age, AMH level, histologic type (ECr vs EIN), and treatment type (LNG-IUS vs MPA) were not significantly associated with CR outcomes ($p > 0.05$ for all). The ROC curve analysis yielded an AUC of 0.455, indicating that AMH level had no meaningful predictive power.

Conclusions

AMH levels were not predictive of treatment success or time to CR in patients FST for endometrial cancer or EIN. These findings suggest that AMH may have limited utility as a biomarker for FST outcomes.

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The Diagnostic Accuracy of the Hysteroscopic Morphologic Patterns in Detecting Endometrial Cancer in Women with Abnormal Uterine Bleeding: A Cross-Sectional Study

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Background

Background: To determine the diagnostic accuracy of hysteroscopic morphologic patterns in detecting endometrial cancer in women with abnormal uterine bleeding.

Methods

Methods: Patients diagnosed with abnormal uterine bleeding secondary to endometrial pathology who are referred for hysteroscopy at a tertiary hospital. One hundred forty-five (145) respondents were included.

Descriptive statistics summarized demographic and clinical characteristics using STATA 13.1. Diagnostic accuracy of hysteroscopic findings was assessed with sensitivity, specificity, PPV, NPV, and likelihood ratios.

Results

Result Histopathologic reports of 145 endometrial biopsies, 123 cases (84.8%) were benign; common findings being endometrial polyps (73.98%) and endometrial hyperplasia (9.76%); endometrial carcinoma accounted for 22 cases (15.2%); Grade I (40.91%); Grade III (22.73%) and Grade II (18.18%) using FIGO grading system. Benign findings at 84.8% (n=123); malignant cases at 15.2% (n=22). Endometrial polyps were frequent, (73.98%); endometrial hyperplasia (9.76%) and endometritis (2.43%).

Papillary pattern showed high accuracy (88.28%) with sensitivity of 81.82% and PPV of 58.06%. Its absence had specificity (89.43%) and NPV (96.49%); Glomerular vascular pattern is accurate, with 77.27% sensitivity, 98.37% specificity, PPV of 89.47%, NPV of 96.03%, and positive likelihood ratio (LR+) of 47.52.

Conclusions

Conclusion Hysteroscopic morphologic patterns are significant for predicting endometrial cancer among women with abnormal uterine bleeding, with glomerular vascular pattern to be the most accurate indicator among six patterns studied. Multiple patterns suggest that hysteroscopic findings offer high specificity for endometrial carcinoma, they often have low sensitivity.

<https://esge.covr.be/cmdocumentmanagement/conferencemanager/documents/api/getdocument/14518/cmabstsms/0000208030/5f378f048b528cb8e99a34f0599c3feec466c2d3a90bd6dd55ab4c86349d21e8>

Comparing two hysteroscopic simulation modalities used at a regional gynaecology simulation course at a teaching hospital in Leeds, UK

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Background

This study aimed to compare user experiences and performance outcomes between two hysteroscopy training models: the SAMED synthetic intra-uterine model trainer and the Storz VR virtual reality trainer.

Both simulators are designed to enhance hysteroscopy diagnostic and operative skills. Their goal is to improve proficiency and reduce complication rates through hands-on simulation.

Training candidates at the annual regional gynaecology simulation bootcamp course used both the VR and intra-uterine models during approximately one hour one-to-one hands-on training facilitated by a trainer for each model.

The SAMED model is a non-digital simulation model that creates a life-like synthetic uterine model allowing use of real operative equipment including morcellation and resecting devices in real time while the VR trainer is a virtual reality-based simulator that uses a virtual environment to replicate the experience of performing hysteroscopy procedures in a virtual setting.

Aims

To evaluate participant feedback and experiences across the two hysteroscopy training models.

Methods

Data was collected from questionnaires completed by attendees of the 2024 LTHT Gynaecology Bootcamp. The cohort included 20 candidates and 2 trainers. Data were analysed using Microsoft Excel.

Results

Among candidates, 55% (11) were year 1, 20% (4) year 2, and 25% (5) year 3.

Across both models, the diagnostic hysteroscopy self assessed entrustability levels amongst candidates showed 20% (4) at Level 1, 75% (15) at Level 2, and 5% (1) at Level 3 while for therapeutic hysteroscopy, training participants revealed 20% (4) at Level 1 and 80% (16) at Level 2.

In terms of similarities to real-life anatomy, most participants selected "Agree" or "Strongly Agree." The VR model had a higher proportion of "Strongly Agree" responses (75%) compared to the SAMED model (55%).

Both models positively impacted skills acquisition and user confidence. However, the VR trainer received more Strongly Agree (80%) compared to the SAMED model (60%) in improving training skills and confidence. Among the trainer participants, all trainers preferred the VR model, with 100%

selecting “Strongly Agree” versus 70% “Agree” for the SAMED trainer. They noted superior functionality in the VR model.

Conclusions

Participants found both hysteroscopic modalities helpful in simulation training. However, the VR trainer was favoured, citing it as more realistic and effective than the SAMED model. Trainers also echoed this sentiment, describing the VR platform as user-friendly and highly beneficial for learning hysteroscopy. VR is described to be better than the SAMED model for all trainees and trainers.

Day case hysterectomy -Increasing the confidence and safety net by use of virtual ward

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Background

The national Getting it Right First time report (2021) identified opportunities to reduce the length of stay for women undergoing hysterectomy by utilizing minimally invasive laparoscopic and vaginal surgery, including vNotes .Our centres have been performing day case hysterectomies for benign diseases through an enhanced recovery pathway, having completed over 200 cases of vaginal hysterectomies in the past decade.

Our standard practice includes comprehensive preoperative counselling, a brief postoperative stay, direct access to the gynaecology ward following discharge, and a telephone assessment on the day after the procedure. This system has generally been effective. However, some patients prefer to stay overnight for reassurance. There are instances where clinicians recommend overnight observation for patients with specific conditions, eg-large uterus removed or residing far from the hospital.

Recently, we have integrated virtual ward in our practice. This remote patient monitoring system is designed to provide hospital-level care within a patient's home. Patients track their vital signs using monitoring devices, and this data is transmitted to a clinical team via digital dashboard. The virtual ward facilitates early identification of any deterioration, allowing for timely intervention, reducing hospital admissions and readmissions. This virtual ward model supports earlier discharge, enhances patient well-being, and eases pressure on hospital resources.

We present preliminary findings from the first 10 patients enrolled in the virtual ward following day case hysterectomy, along with feedback from the operating surgeons.

Methods

Patient experience was assessed through a questionnaire on:

- Satisfaction with preoperative information
- Quality of care during the hospital stay
- Experience with virtual ward monitoring and ease of using wearable technology

Surgeons were surveyed regarding:

- Communication with the virtual ward team
- Confidence in discharging patients on the same day

Results

- **Patient Satisfaction:** All patients (100%) expressed satisfaction with the preoperative explanation, hospital care and the virtual ward follow-up. One patient reported difficulty with the technology and uploading data but remained satisfied with the overall experience.
- **Surgeon Feedback:** All operating surgeons reported high satisfaction with the virtual ward communication and felt it provided peace of mind regarding the postoperative well-being of patients.

Conclusions

Although day case hysterectomy is a well-established service, the integration of a virtual ward adds a significant layer of safety and reassurance for both patients and clinicians. The virtual ward model fosters greater confidence in early discharge, offers personalized care, and helps optimize resource use.

Initial results are promising, with high levels of satisfaction reported by both patients and surgeons.

Patients described feeling safe and well-supported at home. The virtual ward was seen as a reassuring safety net, allowing for a smoother transition from hospital to home

However, it is important to address challenges such as technology usability and to ensure equitable access to this model of care for all patients.

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Uterine Arteriovenous Malformation and Pseudoaneurysm Following Robotic Myomectomy

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Background

Introduction Uterine arteriovenous malformations and pseudoaneurysms are uncommon but serious vascular complications that may arise following uterine trauma or surgery. They can present with delayed or profuse bleeding and are often misdiagnosed as more common postoperative sequelae. Robotic-assisted myomectomy, while increasingly utilised, carries potential risks when dealing with large fibroids or breach of the endometrial cavity.

Methods

We report a rare case of combined uterine arteriovenous malformation and pseudoaneurysm formation following robotic myomectomy. A 35-year-old woman presented with persistent bleeding and delayed haemorrhage shortly after surgery for a large posterior intramural fibroid. Imaging revealed active vascular anomalies, and she was managed with selective arterial embolisation. This case highlights the diagnostic complexity and serious nature of vascular complications following minimally invasive uterine surgery. Early imaging and multidisciplinary management are essential. Timely embolisation allowed bleeding control and fertility preservation.

Case Presentation A 35-year-old woman underwent robotic myomectomy for a 10-centimetre posterior intramural fibroid classified as International Federation of Gynaecology and Obstetrics Type 2–5, with intraoperative breach of the endometrial cavity. She was discharged in stable condition but re-presented within 24 hours with vaginal bleeding and clot passage.

Initial ultrasound revealed a uterine haematoma and a suspicious vascular lesion. Conservative management with tranexamic acid and antibiotics was initiated. However, over the following month she experienced persistent bleeding, culminating in hypotension (blood pressure 96/51 mmHg) and a syncopal episode. Triple-phase computed tomography showed active contrast extravasation and a feeding vessel arising from the left internal iliac artery.

Diagnostic angiography confirmed the presence of both a uterine arteriovenous malformation and a pseudoaneurysm. She underwent successful selective arterial embolisation with coil insertion. Post-procedure, her symptoms resolved, and haemoglobin levels stabilised without further transfusion. She was discharged on iron supplementation, tranexamic acid, antibiotics, and a gonadotrophin-releasing hormone analogue (Triptorelin) to support uterine healing. Fertility preservation counselling was provided, with advice to avoid conception for at least three months.

Results

Discussion This case demonstrates a rare but important vascular complication following minimally invasive uterine surgery. Contributing factors likely included the large fibroid size, endometrial breach, and possibly power morcellation. Persistent or delayed bleeding following myomectomy

should prompt early vascular imaging. Triple-phase computed tomography and diagnostic angiography are key to identifying pseudoaneurysms and arteriovenous malformations. Selective embolisation provides a minimally invasive and fertility-sparing solution.

Conclusions

The use of gonadotrophin-releasing hormone analogues post-embolisation may enhance endometrial repair and reduce recurrence risk. Multidisciplinary collaboration between gynaecology, diagnostic imaging, and interventional radiology is essential for timely intervention.

Combined uterine arteriovenous malformation and pseudoaneurysm can occur following robotic myomectomy, particularly with cavity breach. Early diagnosis and selective embolisation can successfully control bleeding and preserve reproductive potential.

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Laparoscopic transabdominal cerclage: A reliable and effective approach in cervical insufficiency

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Background

To evaluate the clinical outcomes and surgical feasibility of laparoscopic transabdominal cerclage (TAC) in patients with cervical insufficiency who experienced recurrent second-trimester pregnancy losses and failed transvaginal cerclage attempts.

Methods

Nineteen patients with a history of cervical trauma, congenital or acquired cervical anomalies, or unsuccessful transvaginal cerclage underwent laparoscopic TAC in our clinic. Surgical technique, postoperative outcomes, and obstetric results were retrospectively evaluated.

Results

Out of 19 patients, 11 delivered healthy neonates via cesarean section between 37 and 39 weeks of gestation. Four pregnancies are ongoing in the third trimester under close monitoring. One patient experienced intrauterine fetal demise at 24 weeks due to a cardiac anomaly. Two patients have not yet undergone embryo transfer, and one failed to conceive despite transfer. No intraoperative complications were reported. The laparoscopic approach provided adequate visualization, secure placement of Mersilene tape, and a favorable recovery profile.

Conclusions

Laparoscopic transabdominal cerclage is a safe, effective, and minimally invasive surgical option for managing cervical insufficiency in selected patients. It improves obstetric outcomes, especially in cases where transvaginal cerclage has failed. Our clinical experience aligns with the growing body of literature supporting laparoscopic TAC as a reliable intervention to reduce preterm birth and enhance neonatal survival.

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Cost Comparison Between GnRHa injection plus Add-back and Relugolix Combination Therapy in the Management of Endometriosis: A 6-Month Predictive Analysis from a UK Gynaecology Service

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Background

Medical therapy plays a central role in managing endometriosis pain and symptoms. The oral GnRH antagonist Relugolix, combined with estradiol and norethisterone acetate (Ryeqo) has recently been included into NICE Guidance as a suitable alternative treatment to conventional injectable GnRHa + HRT. We compared the 6-month cost burden of these treatments.

Methods

In the interest of simplifying cost implications, we compared the cost of GnRHa + HRT with Ryeqo over a 6 month duration. Although the cost of Triptorelin, Leuprorelin, and Goserelin are similar, the negotiated cost implication to our local health service is that Triptorelin is the cheapest and Goserelin most costly. We also considered the cheapest HRT Tibolone and most expensive HRT Evorel Conti Patches negotiated within our health service at the time of analysis. Due to the variation in clinical practice and service delivery structure, we excluded the consideration of appointment and staffing costs (doctors, nurses etc.), prescription charges, and also excluded cost implications to patients like travel, parking, and loss of earnings to attend appointments or in the event of poor efficacy. The assumption is that patients initiated on the medication are satisfied with results and continues for 6 months.

Results

Over 6 months, Ryeqo costs £518.40 (£86.40x6).

Triptorelin and Tibolone costs £385.20 ((3mg £60x6)+(4.20x6)).

Goserelin and Evorel Conti costs £610.24 ((3.6mg £84x6)+(24 patches £53.14x2)).

Conclusions

Additional consultation time should be factored in when discussing availability of the new treatment alternative Ryeqo. In many location, Ryeqo would be considered an Amber Initiation medication, meaning patients initiated on this need an additional consultant appointment to review suitability prior to primary care continuation, where as GnRHa injections often can have a nurse appointment to review on suitability for GP continuation. Meanwhile Ryeqo reduces administrative and prescription complexity for patients and avoids the need for nurse-administered injections. The cost in the analysis considers the burden on the NHS as a whole, but the cost is usually shared between secondary care and primary care when treatment is delivered over 6 months, and different stakeholders may perceive the cost implications differently depending on how much it would cost their employing organisation rather than the NHS as a whole. Within the UK, NHS patients do not pay for the cost of the drugs but take responsibility on prescription charges and the cost of traveling to attend the pharmacy, hospital or GP so the frequency of visits may pose more of a priority when making a decision on their treatment. Looking at the cost of the drugs alone, Ryeqo appears to have

comparable cost implications to the health service. We stress it is important to preserve the availability of choice rather than concluding if one treatment is better than another due to cost alone.

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Outpatient Endometrial Ablation: A retrospective comparison of Paraostial vs. Fundal Anaesthetic Infiltration

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Background

Endometrial ablation (EA) is a therapeutic option for managing heavy menstrual bleeding (HMB) in women who have not responded to pharmacological treatments, have declined such options, or experience severe symptoms (NICE, 2021). This study aims to compare pain scores in fundal block versus paraostial block during outpatient endometrial ablation (OEA), and to assess patient suitability, tolerability, and the overall efficacy of OEA under local anaesthesia.

Methods

A retrospective analysis was conducted over four years (January 2020 to December 2024) on all women who underwent OEA at a single centre. All patients received pre-procedural oral analgesia, a para-cervical block and either fundal or paraostial infiltration of Levobupivacaine using a Williams needle. Pain scores were assessed using a numeric rating scale and compared between the two techniques. Pain scores were also compared to those for outpatient diagnostic hysteroscopy. Additional data collected included patient age, BMI, device activation time, average power used, endometrial coverage, and endometrial biopsy results.

Results

A total of 73 women were included in the study, with 60 patients receiving fundal blocks and 13 receiving paraostial blocks. The demographics of the fundal block group were as follows: mean age of 45 years (range 34-58 years) and mean BMI of 29.9 kg/m² (range 20-50 kg/m²). The mean device activation time in this group was 81 seconds (range 38-120 seconds). The demographics of the paraostial block group were mean age of 45 years (range 27-54 years) and mean BMI of 31.4 kg/m² (range 23-46 kg/m²). The mean device activation time here was 91 seconds (range 45-120 seconds).

The fundal block group reported a mean pain score of 2.7 while the paraostial block group reported a mean pain score of 1.2. The average pain score for OEA in total was 2.4/10, compared to 5.3/10 for diagnostic hysteroscopy.

Conclusions

OEA under local anaesthesia is an effective, well-tolerated, and safe treatment option for women with heavy menstrual bleeding. Although the paraostial group was relatively small and the procedure may present technical challenges, our experience suggests that it offers more effective anaesthesia when successfully performed. We acknowledge the small sample size in the paraostial group as a limitation, and further prospective studies with larger sample sizes and statistical testing are needed to validate these findings.

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Feasibility and Safety of vNOTES Hysterectomy: A retrospective Case Series of 16 Patients

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Background

Introduction: Vaginal Natural Orifice Transluminal Endoscopic Surgery (vNOTES) is an emerging minimally invasive technique for hysterectomy, offering benefits such as reduced postoperative pain, shorter hospital stays, and improved cosmetic outcomes compared to traditional approaches . This study aims to asses the feasibility and safety of vNOTES hysterectomy through a retrospective case series.

Methods

Materials and Methods: Between October 2024 and May 2025, 16 patients undergoing hysterectomy or adnexectomy for benign gynecological conditions were enrolled in this retrospective study at Hospital General de Catalunya. All procedures were performed using the vNOTES approach by experienced surgeons specialized in minimally invasive gynecologic surgery. Data collected included patient demographics, operative time, estimated blood loss, intraoperative and postoperative complications and length of hospital stay and postoperative pain scores.

Results

Results: All 16 vNOTES (15 hysterectomies & 1 bilateral prophylactic adnexectomy) were completed successfully without conversion to laparoscopic or open surgery. The main surgical indication was heavy bleeding in 11 patients (7 of whom had uterine fibroids), and 4 patients with atypical hyperplasia on a polyp, for whom a bilateral salpingo-oophorectomy was also performed. The mean uterine volume was 92.3 x 55.5 mm (range: 122 x 74mm - 73 x 50mm). Eight patients had one or more previous Cesarean sections. The mean operative time was 100 minutes (range: 60' – 130'), and the mean estimated blood loss was 70 mL. Only one intraoperative complication was observed with significant bleeding due to a tear of the paracervical vessels when introducing alexis, with an estimated blood loss of 700 ml. Postoperative complications have not been observed. The average length of hospital stay was less than 24h in 10 patients (62.5%) and less than 48h in 6 patients (37.5%). Postoperative pain score could not be consistently and were therefore excluded from the analysis.

Conclusions

Conclusions: In this preliminary series, vNOTES hysterectomy demonstrated feasibility and safety for the treatment of benign gynecological conditions. The procedure was associated with favorable

operative outcomes and minimal complications. These findings support the potential of vNOTES as an effective minimally invasive alternative for hysterectomy. Further research with larger patient cohorts and longer follow-up is recommended to confirm these results.

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Transvaginal Ultrasound and Laparoscopy-guided Microwave Ablation for Uterine Myoma and Adenomyosis: Preliminary Results

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Background

To evaluate the effectiveness of microwave ablation (MWA) in treating uterine myoma and adenomyosis.

Methods

This prospective study was conducted at Kaohsiung Medical University Hospital from November 2021 to March 2022. A total of 20 patients (13 with uterine myoma and 7 with adenomyosis) underwent transvaginal ultrasound and laparoscopy-guided percutaneous microwave ablation using a 13-gauge antenna and an Emprint Ablation Generator with Thermosphere™ technology. Treatment efficacy was assessed using the Visual Analogue Scale (VAS) for pain, Pictorial Blood Assessment Chart (PBAC) for menstrual bleeding, and Uterine Fibroid Symptom Quality of Life (UFS-QOL) questionnaire at baseline and 1-, 3-, and 6-12 months post-operation.

Results

Significant improvements were observed in VAS and PBAC scores and UFS-QOL scores at 1-, 3-, and 6-months post-operation ($p \leq 0.05$). There was also a considerable reduction in lesion volume with minimal complications, indicating the safety of the procedure.

Conclusions

Transvaginal ultrasound- and laparoscopy-guided MWA is a promising, minimally invasive treatment option for uterine fibroids and adenomyosis. It significantly improves symptoms and quality of life, with a favorable safety profile. This technique presents itself as a viable alternative to traditional surgical methods, particularly for patients wishing to preserve fertility.

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Robot-assisted laparoscopic hysterectomy for gender affirmation: Experience at a tertiary centre

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Background

In the UK, 0.54% of the population identify as transgender representing a significant minority. Management of gender dysphoria includes psychological, medical and/or surgical approaches, with the rates of those seeking treatment increasing over time. While not all patients with gender dysphoria will choose to have gender affirming surgery with a gynaecologist, it is important to be able to adequately counsel this growing population of patients with regards to their particular risk of undergoing surgery.

Methods

A retrospective analysis was performed of patients undergoing robot assisted laparoscopic hysterectomy (RALH) for gender dysphoria at Chelsea and Westminster Hospital since July 2022. An electronic notes review was performed for the 118 patients identified from theatre lists.

Results

All 118 patients were on testosterone therapy. All patients underwent RALH +-ovarian conservation, 19 patients had additional gender affirming surgery (GAS) under the same general anaesthetic.

Mean blood loss was 20mls. In patients exclusively undergoing gynaecological surgery, mean operative time was 79 minutes, 47% were discharged same day and 90% of patients by the end of day 1. No cases were converted to open.

80% patients had a normal pelvic survey at laparoscopy. There were 8 cases of pelvic adhesions, 6 of endometriosis, 5 of adenomyosis and 1 fibroid uterus. The remaining abnormalities included a thrombosed sigmoid epiploica, a thin walled pararectal cyst and an unobstructed umbilical hernia.

Complications noted intraoperatively included 2 vaginal lacerations and 1 iatrogenic burn to the perineum in a patient while undergoing metoidioplasty.

There were 9 postoperative complications excluding those relating directly to metoidioplasty. 7 minor (Clavien-Dindo (CD) 1-2) and 2 major (CD 3-4). The major complications included a return to theatre for bleeding secondary to a vaginal laceration and a small bowel perforation

Conclusions

Overall complication rates were low, with RALH remaining a safe procedure. The CD 4 complication highlights the importance of appropriate patient selection and work up prior to undergoing elective surgery. The patient with small bowel perforation had a significant goitre awaiting surgery. This resulted in a difficult intubation, and distension of the stomach and small bowel so that nasogastric

tube placement on continuous suction was required in order to visualise the pelvis. Injury was likely at entry.

It is also important to consider, the often significant, vulvovaginal atrophy that can occur in patients on testosterone, in particular, while siting the manipulator and removing the specimen, this may be a contributing factor to the complication rates seen in this cohort.

Pelvic pathology was identified in a minority of patients. The incidence of endometriosis seen at laparoscopy was 5%, much lower than the 10% prevalence often quoted, although this did approach 10% (9%) if adenomyosis was included. This reduced incidence may be due to down regulation by hormonal treatment.

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Ovarian follicular density in women with BRCA1 and BRCA2 mutations: new insights into the negative impact on ovarian reserve.

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Background

Germline mutations of BRCA1 and BRCA2 may impair DNA repair in the ovarian cortex, leading to increased oocyte apoptosis, thus, affecting ovarian reserve. Aim of this study was to assess follicular density in ovarian biopsies from women with breast cancer carrying BRCA1 and BRCA2 mutations who underwent ovarian tissue cryopreservation (OTC) at our center.

Methods

This was a single center, observational, cross-sectional study carried out in a tertiary level referral center for fertility preservation treatment. Exclusion criteria were: patients aged <18 years or >38 years, patients who had already undergone chemotherapy/pelvic radiotherapy at the time of OTC, patients without data on follicular density and those with unknown BRCA mutational status. Follicular density was defined as the number of primordial, intermediate primordial, small primary, large primary, secondary, preantral, and antral follicles per 1 mm² of cortical section area.

Results

Out of 216 patients, 21 women reported germline mutation: 9 (4.2%) were carriers of the BRCA1 mutation and 13 (6%) of the BRCA2 mutation. No significant difference in follicular density was observed among women without BRCA mutations, those with BRCA1 mutations, and those with BRCA2 mutations. The median follicular density was 4.0/mm² (range 0-74.5) in BRCA-negative women, 3.5/mm² (range 0-20) in women with BRCA1 mutations, and 4.0/mm² (range 0-32) in women with BRCA2 mutations ($p = 0.272$ and $p = 0.703$, respectively). After adjusting for age, no statistically significant differences in follicular density were observed according to BRCA1 and BRCA2 mutation status: the median follicular density was 4.6/mm² in BRCA-negative women, 3.1/mm² in women with BRCA1 mutations, and 3.6/mm² in women with BRCA2 mutations ($p = 0.428$ and $p = 0.385$, respectively).

Conclusions

Follicular density appeared to be lower in women with BRCA1/BRCA2 mutations compared to those without the mutation; however, this difference did not reach statistical significance. Our data support the hypothesis that the negative clinical impact of the genetic mutation becomes more pronounced in the later stages of folliculogenesis, characterized by increased somatic cell proliferation. Larger studies are needed to further validate these findings.

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Laparoscopic Excision of Transobturator Tape for Persistent Pelvic Pain and Dyspareunia: A Case Report

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Background

The transobturator tape (TOT) procedure is a widely adopted treatment for female stress urinary incontinence (SUI), offering high success rates and low morbidity. However, complications such as chronic pelvic pain, dyspareunia, and mesh erosion may require surgical intervention. Although rare, complete excision of synthetic mesh may be necessary in cases of persistent symptoms.

Methods

A 50-year-old woman presented to our institution with severe dyspareunia and persistent pelvic pain. The patient reported a history of a TOT procedure performed four months prior. One month after the intervention, the patient was diagnosed with granulation tissue and reported tenderness upon palpation of the skin in the bilateral inguinal fold, as well at the vaginal mucosa along the incision and suture line following the tape placement.

A previous surgical intervention at another facility involved excision of the granulation tissue from both the skin and vaginal areas. However, the patient continued to experience persistent pelvic pain and dyspareunia. Given the ongoing symptoms, a decision had been made to proceed with complete removal of the polypropylene material. To ensure total excision, a laparoscopic approach through the Retzius space was preferred.

Results

Dissection of the Retzius space was carried out, revealing the pubic symphysis. Polypropylene material was identified bilaterally along the urethra, and the tape was dissected up to the obturator muscle. The polypropylene material was completely integrated into the tissue, but it could still be felt with the laparoscopic forceps. The removal of the polypropylene material required deep dissection into the lateral area between the fibers of the obturator muscle. The polypropylene material could not be removed by gentle traction alone; instead, it had to be carefully detached from the surrounding tissue through progressive and gentle dissection until the entire length of the sling, extending under the urethra from one side of the muscle to the other, could be removed. Postoperative recovery was uneventful, and the patient experienced full resolution of pain and dyspareunia.

Conclusions

This case demonstrates that laparoscopic mesh excision is a viable and safe option for treating chronic complications following TOT procedures. Early recognition and a multidisciplinary approach are key to optimizing outcomes in affected patients.

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A Case of Bilateral Ovarian Tumors During Pregnancy Treated with vNOTES

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Background

Transvaginal Natural Orifice Transluminal Endoscopic Surgery (vNOTES) is a minimally invasive technique performed through the vaginal route, which eliminates abdominal incisions and is associated with reduced postoperative pain. Since introducing vNOTES in July 2022, our institution has applied this approach to a range of procedures including hysterectomy, adnexal surgery, myomectomy, and appendectomy. Here, we report a case of ovarian tumor resection via laparoscopically assisted vNOTES during pregnancy.

Methods

The patient was a 33-year-old primigravida with no significant medical history. She was referred to our hospital with a diagnosis of pregnancy complicated by uterine fibroid and bilateral ovarian tumors. At 14 weeks' gestation, pelvic MRI revealed a 6-cm mature cystic teratoma in the right ovary, a 3-cm tumor in the left ovary, and a 6-cm uterine fibroid. Due to the location of the ovarian tumors and the enlarged gravid uterus with fibroid, we anticipated difficulty with a conventional laparoscopic approach.

Results

At 15 weeks and 1 day of gestation, we performed a laparoscopically assisted cystectomy using vNOTES (vLAC). Under general anesthesia, the patient was positioned in lithotomy. The posterior vaginal fornix was incised, and a GelPOINT vPATH port was inserted. Laparoscopic observation revealed the ovarian tumors in the pouch of Douglas. After aspirating the cyst contents, the ovaries were gently drawn into the vaginal canal. Under direct vision, cystectomy was successfully performed. The peritoneal cavity was irrigated, and hemostasis was confirmed. Fetal heartbeat was confirmed immediately postoperatively.

The operative time was 73 minutes with minimal blood loss. The patient experienced mild uterine contractions postoperatively, which resolved spontaneously. She was discharged on postoperative day 2. The remainder of the pregnancy was uneventful, and she delivered vaginally at 40 weeks of gestation with no complications. The postpartum course was also favorable.

Conclusions

In this case, the ovarian tumors were located in the pouch of Douglas, and the presence of a gravid uterus and fibroid rendered the conventional laparoscopic approach challenging. Therefore, vNOTES was considered a safer and more feasible surgical option. This case demonstrates that with appropriate patient selection, vNOTES may be a viable and effective approach for managing ovarian cysts during pregnancy.

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"Pocket-Sign" : a Characteristic Finding of Isthmocele on Hysterosalpingography

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Background

Isthmocele, also known as a cesarean scar defect or niche, has been increasingly recognized as a potential cause of both primary and secondary infertility. Several studies have demonstrated improved pregnancy rates following surgical correction of this defect. Careful evaluation of women presenting with infertility and a prior cesarean section is therefore essential, as overlooking an isthmocele may lead to delayed diagnosis and suboptimal treatment. Although isthmocele is most commonly identified via transvaginal sonography, many women undergoing infertility work-up may initially present with hysterosalpingography (HSG). For this reason, it is of critical importance that clinicians become familiar with the characteristic appearance of isthmocele on HSG to avoid missed diagnosis and to ensure timely management. We aimed to identify and describe a specific hysterosalpingographic pattern—termed the "pocket-sign"—that may serve as a diagnostic clue for isthmocele in women presenting with post-cesarean infertility.

Methods

This retrospective case series included women with secondary infertility and a prior history of at least one cesarean section, who were evaluated between January 2022 and March 2025. All patients underwent hormonal evaluation, semen analysis, transvaginal ultrasonography, and routine HSG as part of their infertility work-up. HSG images were reviewed by two independent observers for contrast pooling in the lower uterine segment during the cavity filling phase. The "pocket-sign" was defined as bilateral symmetrical contrast accumulation adjacent to the isthmic area, creating an image reminiscent of bull horns. The presence of isthmocele was confirmed by transvaginal ultrasound and/or hysteroscopy.

Results

A total of 20 patients presenting with secondary infertility and with suspected isthmocele niche formation in HSG were initially identified. Among these, 12 cases had complete clinical data, including radiological and/or hysteroscopic imaging were included in the analysis. All 12 patients had available hysterosalpingography (HSG) images. In each of these 12 cases, the isthmic accumulation of contrast media-pocket sign-was detected.This specific radiological finding was independently confirmed by two experienced obstetricians and gynecologists in all 12 cases. First 4 HSG images is provided (images 1-4) (figure-1)

Conclusions

In women presenting with secondary infertility and a history of cesarean section, careful attention should be paid during hysterosalpingography to any contrast-filled outpouching near the level of catheter insertion in the lower uterine segment. This widened area may correspond to a uterine

niche and could be compatible with our proposed terminology as "**pocket sign**." Hysterosalpingography is a two-dimensional imaging technique, which limits the visualization of contrast accumulation in the anterior and posterior uterine walls. As a result, contrast pooling is more commonly observed as lateral expansions on the left and right sides of the lower uterine segment. Therefore, this specific pattern should be carefully considered during image interpretation. Clinicians should remain vigilant when interpreting such findings, as they may reflect an isthmocele and warrant further evaluation.

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When Thyroid Meets Ovary: The Rare Case of Malignant Struma Ovarii

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Background

Struma Ovarii (SO) constitutes a rare type of ovarian germ cell tumour, in which the thyroid tissue consists more than 50% of the tumour mass. It represents 2-5% of all mature teratomas. In very rare instances (less than 1%), the thyroid tissue undergoes a malignant transformation, resulting in malignant struma ovarii (MSO), characterized by the presence differentiated thyroid cancer cells. The clinical manifestation varies half of MSO patients are asymptomatic, while others may appear with abdominal pain, or palpable abdominal mass.

Methods

We present a case of struma ovarii diagnosed following a right salpingo-oophorectomy performed due to a sonographically suspicious adnexal mass in a postmenopausal woman. The 58-year-old postmenopausal woman presented in our hospital for a routine year control. Her previous medical history and her last gynaecological control three years ago were uneventful. An abdominal examination revealed a palpable right abdominal mass. The sonographic examination revealed a 3x3cm solid tumour in the right adnexal region, Doppler positive, without ascites (IOTA: B1, M5 / ADNEX Model: 85.2% benign Tumour). The left ovary was normal. The tumour marker CA125 was within normal range (CA125: 6kU/l). The patient underwent laparoscopic bilateral salpingo-oophorectomy and was discharged without any complications. Intraoperatively, the right adnexal region was smoothly enlarged without any other signs of abnormalities. Histopathological examination revealed a papillary thyroid carcinoma, pT1a, within a monodermal mature teratoma of the right ovary. The immunohistochemistry in tumoural cells showed positivity for the specific marker thyroid transcription factor (TTF-1), and for thyroglobulin, consistent with the diagnosis of an ovarian thyroid tissue. Cytology of peritoneal fluid was negative for involvement by carcinoma. Postoperative imaging with PET-CT revealed a minimally metabolically active thyroid struma, with no further suspicious gynaecological lesions for malignancy.

Results

A multidisciplinary tumour board reviewed the case and determined that ongoing follow-up should be conducted by an endocrinologist. The further endocrinological examination including thyroid FNA biopsy and thyroid hormones control was uneventful.

Conclusions

MSO is exceptionally rare and often lacks signs and symptoms. A multidisciplinary approach is needed, as there are currently no guidelines for its management.

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Cervical endometriosis and role of hysteroscopy in its management

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Background

Cervical endometriosis is a rare site and a distinctive entity of this enigmatic disease. It has a different clinical presentation, more difficult diagnosis and dissimilar management approaches.

Cervical endometriosis is subclassified into primary which is limited to the cervix, and secondary which represents an extension from deep pelvic endometriosis. It can also be subdivided into superficial, deep and polypoid.

Methods

Superficial cervical endometriosis is limited to the surface of the cervix with no extension below the squamous epithelium. These patients may present with intermenstrual spotting or postcoital bleeding. Deep cervical endometriosis frequently presents with pain symptoms such as dysmenorrhea and dyspareunia. In case of polypoid cervical endometriosis, the most common symptom is abnormal vaginal bleeding.

Despite the diversity of clinical presentation of different types of cervical endometriosis, the common factor between them is that the diagnosis is usually in retrospect by histopathological examination following a guided biopsy or excision. Superficial cervical endometriosis is commonly misdiagnosed on abnormal cervical smear as cervical glandular intraepithelial neoplasia (CGIN). Deep cervical endometriosis may be mistaken as an invasive cervical tumour. The polypoid type is most likely diagnosed as endocervical polyp or submucous myoma.

Superficial type can be treated by loop excision (LLETZ) or cryocautery. Deep lesions may need excision as part of treatment of the associated endometriosis nodules. The standard management of polypoid cervical endometriosis is polypectomy. However, if the hymenal integrity is to be preserved vagino-resectoscopy offers the ideal treatment option.

Results

A 13-year-old girl presented with severe vaginal bleeding. Transabdominal ultrasound and Magnetic resonance imaging (MRI) revealed a pedunculated mass (90x74x63 mm) arising from the upper part of the posterior endocervix, distending the cervical canal and protruding into the vagina.

Transhymenal vaginoscopy revealed the large mass filling the vagina. Resection of the polyp was performed in 2 sessions (1 month apart) using a bipolar loop resectoscope.

The histological examination demonstrated endometrial glands with surrounding stroma in a background of cervical tissue in correspondence with cervical endometriosis.

Conclusions

To the best of my knowledge, there is no reported cases of cervical endometriosis of this large size in adolescents of that young age. The reported case is a rare example of the possible role of hysteroscopy in the management of some forms of endometriosis.

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The Diagnostic Accuracy of the Hysteroscopic Morphologic Patterns in Detecting Endometrial Cancer in Women with Abnormal Uterine Bleeding: A Cross-Sectional Study Co-authors

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Background

To determine the diagnostic accuracy of hysteroscopic morphologic patterns in detecting endometrial cancer in women with abnormal uterine bleeding.

Methods

Patients diagnosed with abnormal uterine bleeding secondary to endometrial pathology who are referred for hysteroscopy at a tertiary hospital. One hundred forty-five (145) respondents were included.

Descriptive statistics summarized demographic and clinical characteristics using STATA 13.1. Diagnostic accuracy of hysteroscopic findings was assessed with sensitivity, specificity, PPV, NPV, and likelihood ratios.

Results

Histopathologic reports of 145 endometrial biopsies, 123 cases (84.8%) were benign; common findings being endometrial polyps (73.98%) and endometrial hyperplasia (9.76%); endometrial carcinoma accounted for 22 cases (15.2%); Grade I (40.91%); Grade III (22.73%) and Grade II (18.18%) using FIGO grading system. Benign findings at 84.8% (n=123); malignant cases at 15.2% (n=22). Endometrial polyps were frequent, (73.98%); endometrial hyperplasia (9.76%) and endometritis (2.43%).

Papillary pattern showed high accuracy (88.28%) with sensitivity of 81.82% and PPV of 58.06%. Its absence had specificity (89.43%) and NPV (96.49%); Glomerular vascular pattern is accurate, with 77.27% sensitivity, 98.37% specificity, PPV of 89.47%, NPV of 96.03%, and positive likelihood ratio (LR+) of 47.52.

Conclusions

Hysteroscopic morphologic patterns are significant for predicting endometrial cancer among women with abnormal uterine bleeding, with glomerular vascular pattern to be the most accurate indicator among six patterns studied. Multiple patterns suggest that hysteroscopic findings offer high specificity for endometrial carcinoma, they often have low sensitivity.

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Postoperative Urinary Complications in Minimally Invasive vs. Abdominal Radical Hysterectomy: A Meta-Analysis with a Focus on Ureterovaginal Fistula

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Background

Minimally invasive radical hysterectomy (MIRH) has been increasingly adopted as a surgical approach for early-stage cervical cancer. However, concerns have emerged regarding postoperative complications, particularly urologic injuries such as vesicovaginal and ureterovaginal fistulas. This study aims to clarify the comparative risk of such complications between MIRH and traditional abdominal radical hysterectomy (ARH) through a systematic review and meta-analysis.

Methods

A comprehensive literature search was performed across PubMed, the Cochrane Library, Web of Science, ScienceDirect, and Google Scholar up to April 2024. Comparative studies evaluating postoperative urologic complications following MIRH and ARH were included. Meta-analyses were conducted using fixed- and random-effects models. Subgroup analyses were performed based on publication year, study quality, patient BMI, and geographical region.

Results

A total of 35 studies were included in the analysis. Patients undergoing MIRH (N=17,957) had a significantly higher odds ratio (OR) of postoperative urologic complications compared to those undergoing ARH (N=31,878), with an OR of 3.189 (95% CI: 2.637–3.856, $p < 0.001$). Ureterovaginal fistula was the most frequently reported complication (OR: 4.440, 95% CI: 3.398–5.804, $p < 0.001$). Subgroup analyses indicated higher ORs in studies published between 2016–2024 (OR: 3.637, 95% CI: 2.965–4.462, $p < 0.001$) and in those classified as low-quality (OR: 3.981, 95% CI: 3.237–4.897, $p < 0.001$).

Conclusions

Compared to ARH, MIRH is associated with a significantly higher incidence of postoperative urologic complications, especially ureterovaginal fistula. These findings highlight the need for careful surgical planning, patient selection, and possible enhancements in surgical training or technique to mitigate such risks. (CRD42024553756)

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Recurrent torsion of the ipsilateral ovary: a diagnostic and management dilemma - case report

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Background

Ovarian torsion is a gynaecological emergency that arises from the rotation of the ovary, sometimes together with the fallopian tube, around its supporting ligaments, which can result in vascular compromise and loss of ovarian function. Although uncommon, repeated torsion presents substantial diagnostic and management challenges, especially in women with physical predispositions such as elongated ovarian ligaments. Early detection is challenging because of nonspecific symptoms, and while ultrasound with Doppler is the primary imaging tool, it does not always confirm the diagnosis. Conservative surgical procedures, such as detorsion and oophoropexy, are preferable in reproductive-age women for preserving fertility, but recurrence is still of concern.

Methods

A single case report was presented involving a 32-year-old woman with a history of three previous surgeries for right ovarian torsion who presented again with acute lower abdominal pain and vomiting. Imaging showed an enlarged right ovary with a haemorrhagic cyst and no blood flow. Laparoscopy revealed the ovary had twisted three times and appeared black and swollen. After detorsion, the ovary regained blood flow, and a cystectomy and oophoropexy were performed to prevent recurrence. Histology confirmed a benign haemorrhagic cyst with necrosis. The patient recovered well and was started on oral contraceptives to reduce the risk of future torsion.

Results

Intraoperative findings showed the right adnexa twisted three times with a haemorrhagic cyst and no blood flow. After detorsion and cystectomy, the ovary returned to normal appearance and circulation. It was fixed to prevent recurrence. Histology confirmed a benign haemorrhagic cyst with necrosis. The patient recovered well, was started on oral contraceptives, and follow-up imaging showed normal ovaries.

Conclusions

This case demonstrates the difficulty of treating recurrent ovarian torsion, even after several oophoropexy surgeries. While fertility-preserving treatments remain the foundation of treatment, recurrence is still possible. Comprehensive surgical planning, oophoropexy at the proper time, and hormone suppression after surgery may all help to decrease recurrence. Further research is needed to develop uniform guidelines for both the prevention and management of recurrent torsion.

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Review of supraumbilical port site for hernias following laparoscopic gynaecological procedures at a district general hospital in Wales, United Kingdom.

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Background

laparoscopy has become widespread as the standard surgical approach to the abdominal cavity in all surgical specialties including gynaecology. port site hernia is a rare but significant complication, found following 0.1% to 1.8% of gynaecological procedures. it is established that umbilical defects are more common than lateral port-site defects in gynaecology. we were unable to find any reports of or comparison with supraumbilical port site. therefore, our review looked at the occurrence of supraumbilical port site hernias following supraumbilical primary port site placement for laparoscopic procedures in gynaecology.

Methods

we searched electronic databases, reviewing studies on trocar/port site hernias from gynaecology and general surgery. we conducted a two years' retrospective review of all elective laparoscopic gynaecological procedures performed by the particular surgeon at our district general hospital. the primary port was a supraumbilical ten-millimetre bladed visiport trocar. fascial closure was not routinely performed. it was at least 18 months between the most recent surgery and the time of our review. we reviewed digital records of the patients checking through postoperative clinic visits, follow-up surveillance imaging and any referrals to general surgery. we also telephoned all the patients, asking them about clinical features which might signify port site hernias. patients who had possible hernia were then physically examined in a clinic to confirm/refute port site hernia.

Results

data from 52 patients and procedures were included. mean patient age was 56.2years. mean body mass index was 33.9Kg/m². total laparoscopic hysterectomy (tlh) ± unilateral or bilateral salpingo-oophorectomy (bso) accounted for 96.2% of procedures. in all cases, the specimen was removed per vagina. fascial closure was not performed. skin was closed with monocryl absorbable suture. no supraumbilical port site hernias occurred.

Conclusions

the result of our review confirmed the established fact that port-site hernias rarely occur, following only 0.1% to 1.8% of laparoscopic procedures. as we were unable to find any studies involving supraumbilical port sites, it may be that the approach is not used commonly in laparoscopy. therefore, our review and findings support supraumbilical primary port site placement as a safe approach which should be encouraged in clinical practice. also, it highlights the need for more studies involving the supraumbilical approach in laparoscopic surgery.

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Laparoscopic Uterine Artery Coagulation (LUAC) for Treatment of Abnormal Uterine Bleeding, Refractory to Medical Management.

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Background

We are presenting an alternative uterine-sparing treatment, laparoscopic uterine artery coagulation (LUAC), for managing irregular, heavy vaginal bleeding unresponsive to medical therapy.

Methods

A 33-year-old woman presented with persistent, irregular heavy vaginal bleeding. She had a normal BMI, no significant medical history, two vaginal deliveries, two first-trimester losses, and a prior salpingectomy for ectopic pregnancy. Initial hysteroscopy revealed calcified tissue near the uterine fundus, confirmed as chronic retained products of conception, which was removed. Despite this, her symptoms persisted. She declined the levonorgestrel-releasing intrauterine system (LNG-IUS) and instead tried oral medroxyprogesterone, tranexamic acid, and later GnRH analogues with add-back therapy were also used for over six months. These measures failed to control her bleeding. Investigations ruled out coagulopathy and CT-Angiogram and 3D Ultrasound did not reveal any arteriovenous malformations, or significant uterine pathology. Uterine artery embolization (UAE) was deemed unsuitable due to the absence of embolizable feeding vessels.

Following Benign Gynae multidisciplinary team discussion, LUAC was proposed as a management option. A laparoscopy was performed where the broad ligament was opened bilaterally up to the level of uterine isthmus and both uterine arteries were skeletonized. Ascending branch of the uterine artery on both sides was coagulated. After ensuring the haemostasis, UV peritoneal fold was closed with 2-0 vicryl suture. Patient remained well post-operatively and was discharged the next day.

Results

Postoperatively, the patient recovered well and was discharged the following day. At 3- and 6-month follow-ups, she reported complete symptom resolution, regular periods lasting 3-4 days with mild bleeding, and a significant improvement in her quality of life.

For patients with refractory abnormal uterine bleeding (AUB) desiring uterine preservation, treatment options are limited. Hysterectomy remains the definitive surgical solution, while UAE and uterine artery ligation are typically employed in the context of fibroids or adenomyosis. LUAC, as demonstrated in this case, offers a promising alternative for AUB unresponsive to medical therapies. Literature on LUAC for non-fibroid-related AUB is scarce, highlighting the novelty and significance of this approach. Further studies and follow up is required to assess fertility options after this treatment.

Conclusions

LUAC represents an effective and minimally invasive uterine-sparing option for managing AUB refractory to medical treatment. This case underscores its potential to improve patient outcomes.

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Development of an MRI-Based Technique for the Non-Invasive Diagnosis of Adenomyosis in a Murine Model

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Background

Adenomyosis is a benign gynaecological disorder characterized by ectopic endometrial tissue within the myometrium, leading to pain, abnormal uterine bleeding and infertility. While MRI is a widely used diagnostic tool in human adenomyosis, its application in animal models remains underexplored. Murine models of adenomyosis primarily rely on histological analysis for diagnosis, which is invasive and often requires euthanasia. There is a significant gap in non-invasive, longitudinal diagnostic methods for studying adenomyosis in mice, limiting the ability to track disease progression over time or assess therapeutic interventions without resorting to invasive techniques.

Methods

We induced adenomyosis in mice by treating neonatal CD-1 mice with tamoxifen from days 2 to 5 after birth. Control mice received only the vehicle and did not develop adenomyosis. MRI scans were performed once every two weeks from 8 to 24 weeks of age. MRI images were taken of anesthetized mice placed in a horizontal animal probe using a 9.4 Tesla MRI. Anaesthesia was induced with 4% isoflurane in a chamber before the animals were transferred to the animal imaging probe. Isoflurane was continuously delivered via a nose cone. A pressure-sensitive pillow was placed on their back to monitor respiration, the mice were wrapped for insulation and the chamber of the imaging probe was maintained at 25 °C. MRI images were compared between control and adenomyosis groups. Histological analysis of the uteri was conducted post-sacrifice for further comparison.

Results

In the adenomyosis group, T2 hypersignal spots became visible starting at 12 weeks of age, with a progressive worsening of the condition until 24 weeks, leading to extensive disseminated lesions. MRI analysis of the adenomyosis-affected mice showed, compared to controls, a loss of uterine architecture and the progressive development of increasing numbers of cystic lesions leading to diffuse and severe adenomyosis. Histological analysis also confirmed the loss of structure and the presence of extensive cystic lesions. These T2 hypersignal spots are similarly described for MRI-based diagnosis of adenomyosis in humans. The results are highly promising, demonstrating that MRI can accurately detect adenomyosis as early as 3 months of age in CD1 mice with tamoxifen-induced adenomyosis. The findings suggest that MRI could be a reliable tool for precise, non-invasive diagnosis of adenomyosis in murine models, with implications for future studies. One limitation of this technique is that adenomyosis is typically diagnosed at a relatively advanced age in mice, which may hinder early detection due to the disease's progressive nature and the late onset of detectable lesions.

Conclusions

MRI (9.4T) enables non-invasive detection of adenomyosis in a murine model. This novel MRI-based diagnostic approach for murine adenomyosis facilitates longitudinal studies and real-time disease monitoring. It enhances experimental efficiency while minimizing the need for invasive procedures and euthanasia.

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Exploring Robotic Total Hysterectomies: A Multi-Site Experience with the Senhance Surgical System

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Background

This multi-site study, conducted at Klaipeda University Hospital and Academic Teaching Hospital Feldkirch, aimed to explore the safety and feasibility of total hysterectomies with the Senhance Surgical System.

Methods

Patients were recruited and screened for robotic total hysterectomy at Klaipeda University Hospital in Klaipeda, Lithuania and the Academic Teaching Hospital Feldkirch, Feldkirch, Austria. Both sites are part of "The TransEnterix European Patient Registry for Robotic-assisted Laparoscopic Procedures in Urology, Abdominal Surgery, Thoracic and Gynaecologic Surgery" ("TRUST") study group and data are excerpts from this study. Adult patients were included when the indication for total hysterectomy (benign or malign nature) and no absolute contraindications for laparoscopic surgery (e.g., major cardiac or pulmonary diseases that limit CO₂ infiltration) were applied. Patients eligible for laparoscopic surgery were offered robotic surgery if suitable.

Intraoperative complications were defined as adverse events with visceral or vascular injury, cardiopulmonary events, major blood loss (more than 500 mL), or blood transfusion. Postoperative complications were defined as adverse events such as infection, including wound infection and dehiscence, sepsis, ileus, bowel obstruction, blood transfusion, and venous thromboembolic events, occurring within 30 days after surgery. The adverse events were considered severe if readmission or repeated surgery was necessary or death occurred. If any complication occurred, the relation to the robotic procedure was defined, and an international safety committee re-evaluated the connection to the robotic procedure. Written confirmed consent to the robotic procedure was obtained and protocolled from each patient. Demographic data was collected before the procedure. Data was pseudonymized and secured in a database.

Results

The study involved 295 cases, showcasing a well-established routine with minimal procedure times. The average age of the patients was 53.5 years (SD: 10.3 years), ranging from 18 to 80 years. The patients' BMI averaged 25.6 kg/m² (SD: 6.2 kg/m²), ranging from a minimum of 17.7 kg/m² to a maximum of 69.5 kg/m². The duration of surgery varied between 30.0 minutes and 215 minutes, with a median of 95.0 minutes (IQR: 81.0 – 116.0). The docking time was a median of 3.0 (IQR: 2.0 – 5.0) minutes and varied between 1.0 – 30.0 minutes, with a minimum to a maximum range of 1.0 to 122 minutes. Conversion (3 cases, 1%) and adverse events (6 cases, 2%) were infrequent. Additionally, robotic malfunctions were recorded minimally in 4,1% (12 cases) of the procedures, and pain on a 0-

10 visual pain scale was reduced from mild [2.7 (± 1.2)] one day postoperative to minimal [0.9 (± 0.5)] at discharge.

Conclusions

Overall, a great routine with the Senhance Surgical System proves good control and, thus, feasibility and safety. Therefore, the Senhance Surgical System is a viable option for total hysterectomy.

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The role of the setting in controlling anxiety and pain during outpatient operative hysteroscopy: the experience of the hysteroscopy unit in Biella, Italy.

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Background

Anxiety and pain are the primary causes of hysteroscopy failure. For these reasons, in 2024 the hysteroscopists at the Biella hysteroscopy unit greatly improved the environment by creating a comfortable and calm atmosphere for the patients; after these improvements, a retrospective analysis was conducted to evaluate the role of the outpatient setting in controlling anxiety and pain in patients undergoing outpatient operative hysteroscopy, assessing the difference in the rate of patient referral for hysteroscopic procedures in the operating room.

Methods

The sample for evaluation consisted of patients referred to the hysteroscopy service at Biella Hospital in 2023 (470) and 2024 (500). Patients who underwent outpatient operative hysteroscopy in 2024 had the procedure performed in a comfortable environment, created through a combination of background music, white noise, dim lighting, and a quiet atmosphere. In contrast, patients who underwent hysteroscopy in 2023 were treated in an outpatient setting lacking these features.

Results

From the preliminary analysis of the data, it appears that the referral rate to the operating room in 2023 was 11%, compared to a referral rate of 7 % in 2024. Compared to the 2023 sample, the patients who underwent outpatient operative hysteroscopy in 2024 had the only difference of being welcomed into a very relaxing atmosphere free from anxiety-inducing stimuli.

Conclusions

From these data, although preliminary and coming from a small centre, it appears that creating a comfortable setting can truly help patients undergo outpatient operative hysteroscopy by increasing compliance with the procedure and reducing referrals to the operating room. However, further studies are needed to support these findings and to better investigate the role of anxiety and agitation in the failure of these procedures in an outpatient setting.

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Can vaginal natural orifice transluminal endoscopic surgery hysterectomy be performed in patients with an enlarged uterus?

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Background

The feasibility of vaginal natural orifice transluminal endoscopic surgery (vNOTES) for hysterectomy has been established. However, concerns remain regarding its use in patients with an enlarged uterus due to the limited field of view and challenges in accessing the adnexa. Therefore, in this study, the application of vNOTES and conventional laparoscopy (CLS) underwent hysterectomy in patients with enlarged uterus was compared.

Methods

This multicentre study enrolled patients with an enlarged uterus (≥ 300 g) who underwent minimally invasive hysterectomy using either CLS (four ports) or vNOTES in the Department of Obstetrics and Gynaecology between January 2020 and December 2024. All procedures were carried out by highly skilled surgeons in adherence to established protocols, with an estimated 10 cases needed to master the learning curve for each method.

Results

Among the enrolled patients with an enlarged uterus, 39 (65.0%) underwent conventional laparoscopy, and 21 (35.0%) underwent vNOTES. The median operative times were 80 (50-140) min in the conventional laparoscopy group and 70 (60-130) min in the vNOTES group ($P = 0.008$). Median blood loss was significantly lower in the vNOTES group [140 (80-210) vs. 160 (90-370) mL; $P = 0.013$]. The length of hospital stay was comparable between groups. Intraoperative bladder injury occurred in one patient in each group—conventional laparoscopy (2.6%) and vNOTES (4.8%) ($P = 0.651$). Conversion to laparotomy was required in three patients (7.7%) in the CLS group and one patient (4.8%) in the vNOTES group ($P = 0.664$). The visual analog scale (VAS) pain score was significantly lower in the vNOTES group at 6, 12, and 24 h postoperatively.

Conclusions

vNOTES is a safe, feasible, and effective technique for hysterectomy in patients with an enlarged uterus, offering shorter operative times, lower estimated blood loss, reduced postoperative pain, and greater convenience relative to conventional laparoscopy.

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Pseudo-Meigs syndrome associated with uterine leiomyoma: a case report

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Background

Pseudo-Meigs syndrome is a rare condition characterised by the presence of ascites and pleural effusion that resolves after the removal of a non-ovarian pelvic tumour. It is often mistaken for Meigs syndrome, which involves ovarian fibromas. This report presents a rare case of Pseudo-Meigs syndrome associated with a uterine leiomyoma, outlining the clinical features, diagnostic process, and management.

Methods

A 39-year-old Afro-Caribbean woman presented with progressive abdominal distension, discomfort, and shortness of breath. Examination revealed a distended abdomen with ascites and decreased breath sounds at the lung bases consistent with pleural effusion. Laboratory tests showed a mildly elevated CA-125 level.

Imaging, including CT and MRI, revealed an enlarged uterus measuring 17 cm with multiple fibroids—the largest 8 cm—causing mass effect on both ureters. Additional findings included deep endometriosis involving the sigmoid colon, significant ascites, a right-sided pleural effusion and moderate bilateral hydronephrosis. Importantly, there were no suspicious lymph nodes, and cytological analysis of both ascitic and pleural fluids was negative for malignancy.

Results

Given the absence of ovarian tumours and the presence of a large uterine fibroid, Pseudo-Meigs syndrome was suspected. The patient underwent a midline laparotomy, total abdominal hysterectomy with bilateral salpingo-oophorectomy, extensive adhesiolysis, and rectal shaving. Histopathology confirmed benign leiomyomas and endometriosis with no evidence of malignancy. Following surgery, the patient experienced complete resolution of ascites and pleural effusion, confirming the diagnosis.

Conclusions

Pseudo-Meigs syndrome, though rare, should be considered in patients presenting with ascites and pleural effusion, particularly when ovarian pathology is absent. These patients are often referred via urgent cancer pathways due to ascites and raised CA-125. However, detailed imaging and negative cytology can help exclude malignancy and support a benign diagnosis, which is ultimately confirmed histologically.

As demonstrated in this case, surgical removal of the underlying tumour resolved symptoms. This highlights the importance of considering benign gynaecological conditions, such as uterine fibroids, in the differential diagnosis of ascites and pleural effusion. Clinicians should remain vigilant and adopt a multidisciplinary approach to ensure accurate diagnosis and management.

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Asparagine endopeptidase facilitates endometriosis progression and serves as a biomarker for ovarian endometriosis recurrence

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Background

The pseudogene of asparagine endopeptidase (AEP) can promote macrophage M2 polarization in endometriosis (EMs) and thus facilitates EMs progression. However, the relationship between AEP itself and EMs remains unknown. This study is aimed to explore the role of asparagine endopeptidase (AEP) in EMs, and potential as a non-invasive biomarker.

Methods

The expression of AEP was examined by qRT-PCR. The effects of AEP on the progression of endometriosis were explored in vitro and in vivo. The serum AFP of 53 EMs patients and 20 controls from 2013 to 2017 in our centre were examined. A receiver operating characteristic (ROC) curve was applied to test clinical value of AEP. Kaplan-Meier and multivariate Cox regression analyses were conducted to evaluate the correlation between AEP and clinicopathological factors.

Results

In vitro assays demonstrated that AEP can promotes the proliferation, migration, invasion and angiogenesis of ectopic endometrial stromal cell (ECSCs), which contributed the progression of EMs. The effect of AEP on EMs progression was further validated in 3D spheroid model, formed by ECSC and human umbilical vascular endothelial cells (HUVECs), and mouse model. The knockdown of AEP in ECSCs is associated with significant decreased expression of matrix metalloproteinases (MMP)2 which implies that AEP promotes ECSC migration and invasion partly by upregulating MMP2. Clinically, serum AEP was more highly expressed in recurrent EMs patients than in controls and EMs patients without recurrence. Moreover, a novel nomogram was constructed based on serum AEP level, DIE status, and postoperative management which provide better predictions for ovarian EMs recurrence.

Conclusions

Our study illustrated that AEP promotes EMs progression by enhancing cell proliferation, migration, invasion, and angiogenesis via upregulating MMP2 in 2D cell culture, 3D spheroid model and animal experiments. In addition, serum AEP can serve as a novel non-invasive biomarker for predicting recurrence.

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Standardising care for endometrial hyperplasia: a quality improvement project using a hysteroscopy proforma to enhance compliance with RCOG GTG No. 67

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Background

This quality improvement project aimed to evaluate clinical adherence to the Royal College of Obstetricians and Gynaecologists (RCOG) Green-top Guideline (GTG) No. 67 in the management of women diagnosed with endometrial hyperplasia. The objective was to identify areas of non-compliance, implement targeted changes to improve documentation and care delivery, and promote consistency in clinical practice.

Methods

A retrospective audit was conducted at Airedale General Hospital, West Yorkshire, UK, reviewing records of women diagnosed with endometrial hyperplasia between 2017 and 2018, followed up to 2024. Clinical compliance was assessed against RCOG GTG No. 67 standards. Findings revealed specific areas for improvement, which were shared with the clinical team. A re-audit is scheduled to assess the impact of these interventions.

Results

The audit identified deficiencies in BMI documentation and lack of consistent counselling regarding obesity and its association with endometrial hyperplasia. In many cases, there was no recorded communication with the patient or referral to primary care regarding weight management. These findings were presented to the department, leading to the implementation of a modified hysteroscopy proforma. The revised form prompts clinicians to routinely record BMI, address modifiable risk factors such as obesity, and document discussions or referrals made.

Conclusions

High BMI is a modifiable risk factor for endometrial hyperplasia that must be systematically identified and addressed in clinical care. This quality improvement project highlights the importance of structured documentation, patient education, and coordinated management with primary care providers. A standardised hysteroscopy proforma is a practical strategy to enhance compliance with national guidelines, promote consistent follow-up, and support multidisciplinary care. Re-auditing and ongoing quality cycles are critical for sustaining improvements and ensuring alignment with RCOG guidance.

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Re-cervicosacropey with semitendinous tendon transplant (HoTT®-Operation) after a mesh-based laparoscopic cervicosacropey 10 years ago

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Background

Pelvic organ prolapse (POP) is a common problem in older women. Recurrence after surgery can be challenging. Typically, a different procedure than the initial procedure is recommended for repeat surgery. The HoTT® technique (Hornemann tendon transplantation) using the autologous semitendinosus tendon offers a mesh-free alternative to mesh-based laparoscopic cervicosacropey. The objective is to present a re-cervicosacropey using the semitendinosus tendon of the right thigh in a 42-year-old woman with re-prolapse of the cervix. The patient underwent a laparoscopic mesh-based cervico-sacropey combined with laparoscopic Burch colposuspension ten years ago. The patient requested now a mesh-free procedure.

Methods

A 42-year-old female with a history of laparoscopic cervicosacropey with y-mesh and additional colposuspension (Burch procedure) in 2015 presented to our clinic with recurrence of cervical prolapse. Examination showed a rectocele grade II, a cervical prolapse grade III, and a stage 1 cystocele in the anterior compartment. The patient declined conservative management and requested surgical treatment. We planned a vaginal rectocele repair, a laparoscopy with mesh removal and a re-cervicosacropey using the semitendinosus tendon of the right thigh (HoTT®-method). Additionally, a laparoscopic cystocele repair was proposed. To ensure optimal safety of the ureters, we decided to place ureteral catheters and performed intraoperative indocyanine green (ICG) injection for real-time visualization of the ureters.

Results

Despite of remarkable mesh-adhesions, the surgery was done successfully without complications in 197 minutes. A vaginal posterior colporrhaphy was performed to repair the rectocele. A laparoscopy was carried out with an almost complete removal of the previously placed mesh. A repeated cervicosacropey was performed using the semitendinosus tendon harvested from the right thigh and the anterior cystocele was also repaired laparoscopically. The use of ureteral catheters and ICG allowed clear visualization of the ureters during the procedure. The postoperative course was unremarkable, and the patient reported significant symptom relief during follow-up at six weeks, 3 months and 6 months. The histological report revealed a chronic infection of the removed tissue surrounding the mesh.

Conclusions

The case demonstrates four things: first, the excellent visualization of the ureters with ICG for a complication-free mesh removal. Second, the use of autologous tendon tissue from the thigh represents a feasible and effective alternative for fixation of the mid-compartment. Third, the possibility of a laparoscopic anterior colporrhaphy despite previous surgery, forth the presence of a chronic infection associated with the mesh implant.

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Surgical and ethical dilemmas in fertility preservation for a giant uterine mass in a virgin patient

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Background

Uterine myomas are the most common benign tumours in reproductive-age women. However, giant myomas exceeding 15 cm are rare and may clinically mimic malignancy. In virgin patients, diagnostic limitations and ethical sensitivities complicate both evaluation and management, especially when fertility preservation is a priority. We present the case of a 35-year-old virgin patient with a massive uterine fibroid and strong fertility desire, managed with fertility-sparing open myomectomy despite oncologic concern.

Methods

A 35-year-old nulliparous and virgin patient presented with progressive abdominal distension and pressure symptoms. Imaging revealed a giant uterine mass measuring over 20 cm with heterogeneous features suggestive of degeneration. Due to the patient's sexual history and tumour size, transvaginal assessment was limited. The surgical team opted for open abdominal myomectomy via midline incision to allow optimal exposure and minimize uterine trauma. To reduce intraoperative bleeding, both leaves of the broad ligaments were incised, and silicone Foley catheters were looped bilaterally to temporarily compress the uterine arteries. Written informed consent addressed the risk of malignancy and the goal of fertility preservation.

Results

Intraoperatively, the uterus was markedly enlarged, corresponding to a 30–32-week gestational size, and was severely distorted by multiple fibroids. The largest myoma exceeded 18 cm and was located in the anterior intramural wall, occupying most of the uterine corpus. Additional subserosal and intramural fibroids were excised, totalling 11 nodules. Haemostasis was effectively achieved by bilateral uterine artery compression using Foley catheters. Extensive reconstruction was required, and the uterus was repaired using 24 No.1 Vicryl sutures in multiple layers to restore anatomical structure and preserve endometrial integrity. Frozen section analysis was benign; final pathology confirmed leiomyoma with areas of hyaline and cystic degeneration. Estimated blood loss was moderate (not requiring transfusion). No intraoperative or postoperative complications occurred. Menstrual cycles resumed by the sixth postoperative week, and the patient expressed high satisfaction with both functional and aesthetic outcomes. She is now under follow-up for fertility planning.

Conclusions

Giant myomas in virgin patients present unique surgical and ethical challenges. When minimally invasive access is not feasible, midline laparotomy allows effective exposure. Temporary uterine artery occlusion using Foley catheters offers a reversible, fertility-sparing haemostatic strategy.

Careful preoperative planning, layered uterine reconstruction, and patient-centered counselling are key to successful outcomes in such complex cases.

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Reproductive outcomes of hysteroscopic metroplasty in T-shaped uterus

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Background

T-shaped uterine anomalies are commonly caused by disruptions in intricate reproductive tract development. Hysteroscopic metroplasty is the modern treatment option, yet comprehensive information on its effectiveness is lacking, particularly in East Asian populations.

Methods

Using data from a tertiary centre, specialised in infertility between 2012 and 2022 (Teba Centre), a retrospective study analysed 216 out of 16570 females with infertility, aged between 16 and 46 years old, that were diagnosed as having congenital T-shaped uterus. Of these, 83 chose not to undergo surgery, and 133 underwent hysteroscopic metroplasty. A thorough analysis was conducted on the patients' demographics, gynaecologic history, reproductive outcomes and diagnostic imaging findings. The diagnosis was guided by the 'ESHRE/ESGE classification' or during hysteroscopic ambulatory diagnosis.

Results

Significant differences were observed between the metroplasty group and the no-surgery group (uncorrected t-shaped uterus group). In the metroplasty group, the pregnancy rate was significantly higher than in the no-surgery group (57.9% vs. 32.5%, $p < 0.001$). Implantation failure and recurrent pregnancy loss significantly decreased ($p < 0.001$) with hysteroscopic metroplasty.

Conclusions

Females with a T-shaped uterus who underwent metroplasty experienced significant improvements in reproductive and obstetrical outcomes including higher pregnancy rates, increased live births, more term deliveries, and lower incidences of abortion and stillbirth, compared to those who did not undergo surgery.

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Correlation of serum AMH level and radiologic markers calculated with ultrasonography and MRI in patients with unilateral endometrioma

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Background

The study aimed to evaluate ovarian reserve markers in patients with unilateral endometrioma by comparing anti-Müllerian hormone (AMH) with various imaging markers using ultrasonography and MRI.

Methods

This retrospective, observational study included women diagnosed with endometrioma via imaging at single, tertiary hospital between 2015 and 2023. The patients' ultrasonography and MRI were employed to measure ovarian and endometrioma size, using various absolute and relative indicators. Blood samples were taken to assay AMH and inflammatory markers, and statistical analyses were performed to explore associations between AMH and calculated imaging markers, with significance set at p -value of <0.05 .

Results

A total of 146 women with a mean age of 32.01 ± 5.99 years and a mean AMH level of 3.54 ± 3.24 ng/mL were included. The mean volume of endometrioma was 63.54 ± 84.42 mL via ultrasonography and 59.71 ± 101.90 mL via MRI. A negative correlation was found between serum AMH levels and both age and BMI. While most ultrasound parameters did not correlate with AMH levels, MRI parameters such as the maximum diameter, mean diameter, and volume of the healthy ovary did show a significant correlation.

Conclusions

The findings suggest that the volume of the healthy ovary, as measured by MRI, can provide valuable information in assessing ovarian reserve. This additional measure can enhance clinical decision-making in managing endometriosis in reproductive-aged women.

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High-intensity focused ultrasound ablation combined with hysteroscopic myomectomy to treat diffuse uterine leiomyomatosis: a case report and literature review

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Background

Diffuse uterine leiomyomatosis (DUL), a benign uterine disorder mimicking adenomyosis, often leads to diagnostic confusion. A 26-year-old nulliparous woman with refractory abnormal uterine bleeding was initially misdiagnosed as adenomyosis by ultrasound.

Methods

Pelvic MRI confirmed DUL. Treatment combined ultrasound-guided high-intensity focused ultrasound (HIFU) ablation, gonadotropin-releasing hormone agonist (GnRH-a) therapy, and hysteroscopic resection of submucosal lesions. A levonorgestrel-releasing intrauterine system (LNG-IUS) was inserted postoperatively for long-term management.

Results

Over three years of follow-up, the patient achieved regular menstrual cycles, complete resolution of bleeding and dysmenorrhea, and no recurrence. Quality of life significantly improved without complications.

Conclusions

MRI is essential to avoid misdiagnosis of DUL in refractory bleeding cases. The multimodal approach—HIFU, hysteroscopy, hormonal therapy, and LNG-IUS—may effectively control symptoms while preserving fertility, offering a tailored strategy for reproductive-age women.

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Is myomectomy necessary before ART? A narrative review.

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Background

Uterine fibroids have been associated with adverse obstetric outcomes like spontaneous abortions, intrauterine growth restriction, preterm labour, abdominal pain during pregnancy and higher incidence of caesarean section as well as postpartum haemorrhage. However, the association between infertility and fibroids remains a debate. This study is aiming to recognise when myomectomy is necessary before undergoing assisted conception.

Methods

An electronic database search of all published studies in PubMed, EMBASE and Google Scholar from 2004 to 2024 was performed with following keywords: uterine fibroids, leiomyomas, myomectomy, assisted reproductive technology (ART), in vitro fertilisation treatment (IVF) and infertility. Only scientific papers published in English language were included.

Results

Subserosal fibroids are not associated with infertility, they might influence though uterine contractility and gamete migration, myomectomy though is not suggested before IVF treatment. Intramural fibroids have been associated with lower implantation rate, clinical pregnancy and live birth rates, as result their removal is advised. There is fair evidence that hysteroscopic myomectomy for submucosal fibroids improves ART outcomes and clinical pregnancy rates.

Conclusions

For specific type of fibroids data is fair, mainly due to studies' heterogeneity. It looks though that large subserosal fibroids is better to be removed before ART, even it is not clear their exact role in fertility. More studies better designed are necessary to recognise the role of fibroids before ART and manage them accordingly.

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Impact of vaginal cuff closure on post-operative sexual function outcomes: VCOS Study

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Background

Vaginal cuff closure during hysterectomy may be performed using a horizontal or vertical orientation, yet limited data exist on how closure technique influences postoperative sexual function. The objective of this study was to assess the association between vaginal cuff closure orientation and postoperative sexual function using a validated sexual function instrument.

Methods

Design: Cross sectional cohort study.

Setting: A single tertiary academic medical centre.

Patients or Participants: All women who underwent hysterectomy for benign indications via robotic, laparoscopic, or vaginal routes between January 2023 and September 2024 were eligible for inclusion.

Interventions: Eligible women were contacted by telephone and invited to complete the Female Sexual Function Index-6 (FSFI-6), a validated tool assessing six domains of sexual function. Total scores range from 2 to 30, with scores ≤ 19 indicating risk of female sexual dysfunction (FSD). FSFI-6 scores were analysed in relation to vaginal cuff closure orientation (vertical vs. horizontal) and surgical approach.

Results

A total of 45 women responded to the questionnaire, of them 23 in the vertical closure group and 22 in the horizontal closure group. Age, marital status, parity and body mass index (BMI) were comparable between the groups. The most common indication to perform the procedure was due to abnormal uterine bleeding caused by fibroids contributing 40% of women in both groups. 21 (91%) and 16(73%) of the women in the vertical and the horizontal groups, respectively, indicated they were sexually active before the procedure. Interestingly, while asked about sexual activity following the procedure, a reduction was noted in the vertical group (83%) versus increase in the horizontal group(82). The change was not found statistically significant. The total questionnaire score was found 16(10-18) for the vertical closure versus 18(13-20) for the horizontal closure ($p=0.37$). A total score >19 was observed in 7% of the vertical group and 32% of the horizontal group, although this difference was not statistically significant.

Conclusions

While no significant differences were observed, trends suggest horizontal cuff closure may be associated with more favourable sexual function outcomes post-hysterectomy. Larger, prospective studies are needed to confirm these findings and inform surgical best practices.

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Putting the Spotlight on Surgeons: Work-Related Injuries in Minimally Invasive Surgeons (WRIM Study)

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Background

Surgeons practicing minimally invasive surgery (MIS) encounter significant ergonomic challenges, contributing to a high prevalence of work-related musculoskeletal injuries (WRIs).

Methods

Objective: This study aimed to evaluate MIS surgeon's perceptions of their health, the prevalence of WRIs, and their awareness of ergonomic principles.

Study Design: A cross-sectional study was conducted among surgeons practicing MIS across various subspecialties, including gynaecology, urology, orthopaedics, general surgery, paediatrics, plastic surgery, and otolaryngology. Surgeons were invited to complete an anonymous electronic questionnaire addressing lifestyle factors, general health, WRIs, ergonomic practices, and preventive measures. Completion of the questionnaire implied informed consent.

Results

The study included 69 MIS surgeons, with a balanced gender distribution (48% female, 52% male). The mean age of participants was 45 years. The majority (56.5%) had over 10 years of surgical experience, with most performing 5–10 weekly surgeries. Robotic surgery was the predominant approach for only 10% of surgeons. While 84% of participants self-reported good general health, approximately 50% experienced WRIs, predominantly involving the neck, back, and wrists. Females reported significantly higher rates of WRIs than males (69.7% vs. 30.6%, $P = 0.001$), yet preventive measures were adopted inconsistently, with males more frequently changing surgical approaches. Robotic-assisted surgery alleviated some ergonomic risks but was associated with higher rates of neck pain (43.5%) compared to non-robotic approaches (21.7%, $P = 0.06$).

Conclusions

WRIs are prevalent among MIS surgeons, with notable gender disparities in injury prevalence and preventive strategies. These findings underscore the urgent need for targeted ergonomic education, gender-sensitive interventions, and system improvements to enhance surgeon well-being and professional longevity

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Pregnancy outcome after uterine artery embolization for uterine adenomyosis

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Background

Uterine adenomyosis involves the growth of endometrial glands and stroma within the uterine musculature. Patients, with uterine adenomyosis, experience heavy painful periods, deep dyspareunia and subfertility, with reduced their overall quality of life. Hysterectomy is usually the recommended treatment for such patients. Whilst Uterine Artery Embolisation (UAE) offers a suitable, fertility-preserving alternative, for patients who have not completed their families, its impacts on pregnancy outcomes have not yet been explored or studied in women with pure adenomyosis. The aim of this study was to assess pregnancy outcome and live birth rates in women with pure adenomyosis, treated with UAE.

Methods

We performed a comprehensive systematic review of the published literature in Pubmed, Embase, Cochrane, Google Scholar, Scopus and ClinicalTrials.gov from January 2000 until January 2025. All published and unpublished literature in English language, describing pregnancy outcome after uterine artery embolization for pure uterine adenomyosis, were eligible for inclusion in the study. Data about preconception characteristics, pregnancy, obstetrics and neonatal outcomes were extracted and analysed according to study design of source and pregnancy viability

Results

We identified nine papers, with a total cohort of 611, 139 desiring fertility. Women were aged 18-52, with a mean follow up of 46.3 months after UAE. We concluded a pregnancy rate of 25.2% (n=35) and a live birth rate of 74.2% (n=26) in this cohort. Of these, 7 studies reported obstetric and/or neonatal complications, including preterm, premature rupture of membranes, antepartum and /or postpartum haemorrhage, low birth weight and neonatal deaths.

Conclusions

The pregnancy and live birth rates, after UAE for pure uterine adenomyosis are comparable to IVF clinical success rates. Uterine Artery Embolization provides a foundation for further studies and research, directly assessing pregnancy outcomes and indirectly assessing the fertility potential in women with pure adenomyosis, with the potential to influence uterine adenomyosis treatment guidelines. Future research should explore both pregnancy outcomes as well as fertility markers to differentiate the direct effects of UAE on pregnancy, as opposed to other confounding factors.

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Comparative analysis of obstetric outcomes following artificial and natural cycle frozen embryo transfer in patients with and without endometriosis: a national cohort study

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Background

This study compared the effects of artificial cycle frozen embryo transfer (AC-FET) and natural cycle frozen embryo transfer (NC-FET) on pregnancy and obstetric outcomes in patients with and without endometriosis using a national cohort from the Republic of Korea.

Methods

We analysed data from the National Health Insurance Service database (October 2017 to December 2021), including 44,118 singleton pregnancies following in vitro fertilization. The AC-FET and NC-FET groups were distinguished based on prescription records, and patients were further categorized into endometriosis and non-endometriosis groups using the ICD-10 code N80. Logistic regression models were used to compare outcomes between AC-FET and NC-FET, and interaction analyses assessed whether endometriosis modified the effect of FET protocols.

Results

In patients with endometriosis, AC-FET was associated with a higher risk of preterm birth before 37 weeks (adjusted odds ratio [AOR] 2.83, 95% CI 1.04–7.75) compared to NC-FET, whereas no significant difference was observed in non-endometriosis patients. The risk of threatened abortion was also significantly higher in patients with endometriosis (AOR 2.02 vs. 1.51), with a significant interaction ($P = 0.046$), suggesting that endometriosis may amplify early pregnancy instability under AC-FET. For hypertensive disorders of pregnancy and placenta previa, the AORs were also higher in the endometriosis group.

Conclusions

AC-FET was associated with increased risks of adverse obstetric outcomes, including threatened abortion, preterm birth, hypertensive disorders, and placenta previa. These risks were more pronounced in patients with endometriosis, indicating that NC-FET may be preferable for this population.

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Laparoscopic management of bowel perforation secondary to levonorgestrel-releasing intrauterine device migration:

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Background

Levonorgestrel-releasing intrauterine devices (LNG-IUDs) are widely used for contraception and the management of gynaecologic conditions such as menorrhagia, dysmenorrhea, and endometriosis. Although uterine perforation is a rare complication, bowel perforation due to IUD migration is exceedingly uncommon, particularly with LNG-IUDs. Most reported cases involve copper IUDs. We present a rare case of sigmoid colon perforation caused by a migrated LNG-IUD.

Methods

A 54-year-old woman with a history of LNG-IUD insertion in 2000 presented with intermittent rectal bleeding and left lower quadrant pain in 2022. The IUD had not been visualized during a removal attempt in 2007, and spontaneous expulsion was presumed. Physical examination revealed only mild tenderness. Colonoscopy identified a foreign body penetrating the sigmoid colon wall. Imaging via abdominal X-ray and CT confirmed the presence of an IUD embedded in the colon and adjacent to the uterus.

Results

The patient underwent laparoscopic anterior resection with left salpingo-oophorectomy due to severe adhesions between the sigmoid colon and left adnexa caused by the migrated LNG-IUD. The IUD was successfully removed, and the patient recovered without complications. This case underscores the potential for delayed bowel perforation long after undetected IUD migration.

Conclusions

Although rare, LNG-IUD migration can result in bowel perforation, even years after insertion. If an IUD is not identified within the uterine cavity on ultrasound, further evaluation with abdominal CT should be considered. In symptomatic or high-risk cases, surgical intervention—preferably laparoscopic—should be considered over conservative management due to the potential for serious complications such as bowel injury.

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The role of vaginal natural orifice transendoscopic surgery in gynaecological emergencies

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Background

Transvaginal natural orifice transluminal endoscopic surgery (vNOTES) is an innovative and minimally invasive technique that is gaining popularity for a range of gynaecological procedures. Although the current body of evidence for vNOTES is somewhat smaller compared to conventional laparoscopy, this approach appears to have several distinct benefits, such as reduced blood loss, shorter operation times, minimized postoperative pain, faster recovery and discharge from the hospital, better cosmetic results, and lower rates of complications after surgery. While an increasing number of studies support the use of vNOTES in planned adnexal procedures, its safety and practicality in emergency settings remain inadequately explored. This report aims to present our experience with using vNOTES to manage gynaecological emergencies.

Methods

A retrospective analysis was conducted on data from patients who underwent vNOTES for gynaecological emergencies between January 2023 and April 2025. Demographic information and perioperative details were also collected and evaluated.

Results

A total of nineteen patients were included in the study. The procedures were performed to address suspected ectopic pregnancies in 10 patients (52.6%), suspected adnexal torsions in another 3 patients (15.8%), hemoperitoneum following hysterectomy in 1 patient (5.3%), pelvic abscess in 1 patient (5.3%) and cyst rupture in 4 patients (21.1%). The emergency surgical interventions comprised unilateral salpingectomy (52.6%), ovarian cystectomy (21.1%), adnexal detorsion (15.8%), hemoperitoneum drainage (5.3%) and abscess drainage + appendectomy (5.9%). The median duration of surgery was 34 minutes, with a range of 24 to 65 minutes. Estimated blood loss during procedures had a median value of 140 mL, ranging from 30 to 300 mL, and no intraoperative complications were noted. None of the surgeries required conversion to traditional laparoscopy or open surgery. Post-surgery, the median hospital stay was 2 days, ranging from 1 to 4 days. Postoperative pain, evaluated using the visual analog scale, showed a median score of 2 (range: 1-4) at 24 hours following the surgeries. There were no procedure-associated complications observed.

Conclusions

This study demonstrated that vNOTES procedures present a viable approach for managing gynaecological emergencies, including tubal ectopic pregnancy, adnexal torsion, painful ovarian lesions, post-hysterectomy hemoperitoneum, and uncontrollable uterine bleeding. When combined

with data from existing research, our results indicate that vNOTES may provide certain advantages over traditional laparoscopy for addressing these conditions

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Safe performance of total laparoscopic hysterectomy in women who gave birth by cesarean section

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Background

Patients who have had a previous caesarean section (CS) are at higher risk for perioperative complications after a total hysterectomy. We performed this study to evaluate the safety of total laparoscopic hysterectomy (TLH) in women who had previously undergone caesarean section.

Methods

This study was conducted on 453 patients treated for TLH. The surgical outcomes including major complications were compared between patients who had never had a caesarean section (no-CS group) and those who had had a caesarean section (prior-CS group). Vaginal dehiscence, major vascular, bowel, bladder, ureteral, and bowel injuries were considered major complications.

Results

There were no significant differences between the groups in terms of major complications, uterine weight, length of hospital stay, unscheduled transfusions, or conversion to laparotomy. One bowel injury occurred in the no-CS group. In the prior-CS group, there were two cases of vaginal cuff dehiscence and one bladder injury. No injuries to the ureters or major blood vessels were reported.

The operation duration was longer ($p = 0.04$) in the prior-CS group, although the difference was only seven minutes compared to the no-CS group. The duration of Foley catheter indwelling was also significantly longer ($p = 0.01$) in the prior CS group, but did not exceed one day. The number of prior caesarean sections had no impact on the rate of major complications. No long-term sequelae were observed following the treatment of major complications.

Conclusions

Total laparoscopic hysterectomy (TLH) can be performed safely in patients with a history of CS, as such history does not affect the rate of major complications. Complications were rare and were managed successfully.

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Bariatric surgery and Infertility. A 2-way interaction

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Background

Obesity is an ongoing pandemic, which has a major impact on women's health. The hyper estrogenic state associated with obesity has a promoting effect on endometrial tissues, uterine fibroids, endometriotic lesions, in addition to ovulatory dysfunction.

Bariatric surgery has gained a lot of momentum in the past few years, and in gynaecological practice, women are often seen after having done such procedures.

In this review, we propose a hypothetical interaction between women's health in general, and fertility problems in particular, and bariatric surgeries.

Methods

We have been exposed, over a long history of practice in the field, to women who have undergone bariatric surgery procedures, both in before- and after- situations. It has drawn our attention that there exists an interplay between both female infertility and bariatric procedure. This is not restricted to the commonly spoken of impact of loss of weight, caused by bariatric surgery, and improved reproductive potential, but we have observed an impact of female fertility problems on their need of such procedures, as well as the outcomes of these interventions.

Results

There seems to be a bi-directional interaction between bariatric procedures and female infertility issues. Women with PCOS tend to have a higher BMI and hence are more in need of such procedures. On the other hand, PCOS makes women more prone to post-operative adhesions after bariatric surgeries, and even make them more prone to re-gaining weight, ending in a need for re-procedure.

Another example of such 2-sided interaction is in women with endometriosis, where hypoestrogenic state in obese women seems to promote the growth of endometriotic lesions, and it would sound logical that bariatric procedures, resulting in weight loss, will lead to some regression of such lesions. However, we have noted a tendency to more aggressive nature of endometriosis after bariatric surgeries.

These are just examples of the many ways infertility and bariatric surgeries are intermingled

Conclusions

Infertility and bariatric surgeries are intermingled in ways beyond the traditional understanding. This

calls for improved collaboration and communication between minimally invasive gynaecological surgeons and bariatric surgeons through multi-disciplinary teams.

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Deep Infiltrating Adenomyosis!

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Background

Adenomyosis simply refers to the presence of endometrial glands inside the myometrium. It is associated with many gynaecological complaints, such as heavy menstrual bleeding, dysmenorrhea, and chronic pelvic pain. Furthermore, it negatively impacts the reproductive potential of women and is associated with infertility.

With the rising incidence of CS worldwide, post-operative adhesions at the CS scar site are on the rise. Of particular importance is the adhesions between the hysterotomy site and the anterior abdominal wall.

Methods

We present our experience with a large series of cases with adenomyosis uteri, in whom dense adhesions were found between the CS hysterotomy site and the anterior abdominal wall, on performing laparoscopy for various indications, such as infertility or chronic pelvic pain.

Results

Very dense were encountered between the CS hysterotomy site and the anterior abdominal wall in a large cohort of women with adenomyosis. The adhesions in such ladies were so dense that no dissection planes could be identified to separate the uterus from the parities. Such lack of discrimination of layers, and "melting" of tissues gave rise to an impression that adenomyotic tissues were infiltrating the adjacent abdominal wall layers, that we feel we may call this "deep infiltrating adenomyosis", as is the case with deep infiltrating endometriosis.

Conclusions

Uteri with adenomyosis are at higher risk to be involved in dense post-CS adhesions with the anterior abdominal wall. Such adhesions are particularly dense, and difficult to dissect that they give an impression that adenomyotic tissues do tend to infiltrate the adherent tissues. This needs to be considered during assessment and management of women with previous CS and adenomyotic uteri, presented with various gynaecological complaints.

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Six selection!!

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Background

Peri-hepatic adhesions, although very far away from the gynaecological operative field, may be encountered during the 360-degree overview of the peritoneal cavity. They may even be caused by gynaecological procedures, such as hystero-salpingography (HSG), or a gynaecological disease namely pelvic inflammatory disease (PID).

Methods

From our case series of female patients undergoing laparoscopy for various gynaecological indications (ranging from infertility to bleeding and pelvic pain), we have seen many cases with peri-hepatic adhesions. We believe that a competent endoscopist should be able to manage many intra-abdominal pathologies, including this kind of adhesions. To that aim, it is important to have some prediction of the presence of such lesions ahead of the laparoscopy itself to help the gynaecological endoscopist be prepared to manage such lesions and deliver the best outcome to the patient.

Results

Reviewing the history and clinical signs given by these patients and comparing their symptoms before and after laparoscopic lysis of perihepatic adhesions, we have identified a number of "telling complaints" that help direct the attention of the gynaecologist in the clinic to the possibility of finding these adhesions during laparoscopy in the operating room.

Conclusions

A number of revealing symptoms, although they may seem out of scope of the traditional gynaecological history taking provided good correlation to the intra-operative finding of peri-hepatic adhesions. Awareness of such symptoms, and seeking them will help the gynaecological endoscopist be prepared to deal with such adhesions in order to provide symptomatic relief and best outcome to the patient

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Uterine A-V Malformations. From surprise presentation to happy delivery

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Background

Arterio-venous malformations of the uterus is a rare pathological lesion that may affect the myometrium. It often presents with abnormal uterine bleeding, including obstetric abnormal bleeding episodes. Management of such cases requires diligent evaluation and careful management, as messing with these highly-vascular lesions may itself cause massive bleeding.

Methods

We report the case of a young woman, who presented to our centre with recurrent post-abortive bleeding after her only pregnancy, for which she has undergone dilatation and curettage twice, suspecting remnants of conception. However, bleeding persisted as she came to us for evaluation and management.

Results

Gestational trophoblastic Disease (GTD) was firstly excluded by a negative HCG test. Ultrasonographic evaluation revealed an empty endometrial cavity, apart from a rim of blood. However, there was a cystic mass to the left side of the uterus, encroaching on the broad ligament, measuring 35 x 40 mm. Doppler study revealed a highly vascular nature of the lesion. The decision was taken, after patient counselling, for combined laparoscopy and hysteroscopy for better evaluation and management of the lesion, keeping in mind it could still be a GTD, such as placental site tumour. Hysteroscopy revealed a cavity distended with blood, but no focal lesions. Laparoscopy, however, revealed a 5-cm mass at the left broad ligament, which was highly vascular. We decided to carefully check the planes of cleavage around this mass, keeping in mind that we will stop our dissection and refer the patient for interventional radiology if any signs of excessive bleeding or absence of cleavage planes were encountered. Fortunately, the mass was well-circumscribed, and we managed to enucleate it with minimal bleeding till the pedicle. Post-operative histopathological examination confirmed the diagnosis of an A-V malformation. We followed this lady post-operatively, where she recovered well, and continued to follow her up until she got pregnant again. This time, her pregnancy progressed smoothly, until she delivered with us a healthy baby at term.

Conclusions

Arterio-venous malformations of the uterus is a rare entity, which may present with both gynaecological and obstetric problems. Accurate diagnosis and diligent management results not only in a safe outcome, and also a happy result for the patients.

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Ovarian Goiter!

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Background

Cystic teratoma is a special type of ovarian tumours, characterized by the presence of one or more of germ cell lines, endo-, ecto- or meso-derm. Ectodermal and mesodermal elements are most frequently encountered, giving rise to the famous mix of sebaceous material and hairs, most characteristic of these tumours.

Methods

We have come across many cases of typical and atypical presentations of dermoid cysts, over our years of gynaecological practice. Some of these cases had very bizarre histopathological findings, including prostate-like tissues!

In the current case presentation, of a young lady, presented with sonographically-suggested dermoid cyst of the ovary, the histopathological exam report was quite unusual, that the histopathologist had to return to the OR department twice to exclude a mix-up of samples!

Results

Histopathological examination of the laparoscopically-extracted cyst was identical to thyroid gland tissues. The histopathologist even suspected the source of the sent specimen, and had to re-check the source of the specimen.

Surprisingly, the patient's thyroid functions test (TSH, free T3, free T4) were all normal.

Conclusions

Mature cystic teratoma is a unique type of ovarian tumours. All extracted specimens should be sent, whole and intact, for histopathological examination. Communication between the gynaecologist and the histopathologist is important, especially with unusual findings.

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The effects of hormonal and hormone-blocking treatments for endometriosis on mental health: systematic review and narrative evidence synthesis.

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Background

Endometriosis affects 1 in 10 women and can cause debilitating pain and subfertility resulting in poor physical, mental and emotional health. Medical therapies largely comprise of hormonal suppression however in our London-based tertiary endometriosis centre a considerable proportion of patients report mental health side effects from these treatments. We systematically searched and synthesised the available evidence to understand how hormonal and hormonal-blocking treatments affect mental health for women with endometriosis. We aimed to assess the frequency and severity of mental health side effects from hormonal and hormone-blocking treatments and ascertain whether mental health side effects have been adequately studied to help women make informed evidence-based choices.

Methods

PROSPERO registration performed prior to database searches on Pubmed, OVID, AMED, Embase, Emcare, Ovid MEDLINE(R), Web of Science, PsycINFO, CINAHL, Cochrane Central to identify studies that reported impact of hormones/hormonal-blocking-treatments for women with endometriosis.

Results

457 studies were identified from databases/registers; 455 studies screened, 95 studies sought for retrieval, 95 studies assess for eligibility with 63 studies included in the review. Depression scores before and after treatment generally showed a significant improvement in depression and anxiety and improved quality of life. However, severe cases of de-novo depression brought on by hormonal endometriosis treatments were reported.

Conclusions

We can reassure patients that overall hormonal treatments improve mental health, but some individuals will have an intolerance to synthetic progesterone or hormone-blockers, which can result in poor mental health. Adequately powered studies are needed to qualify this effect, and to understand its mechanism.

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Advancing Equity in Fibroid Care: A Pilot Study of Gynaecologist's Perspectives on Interventions, Availability and the Future of Services in the United Kingdom

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Background

Uterine fibroids are the most common tumour of the female genital tract and disproportionately affect ethnic minority women. These women may be excluded from certain treatment modalities based on disease severity and the availability of surgical expertise. Surveys on intervention for fibroids have consistently highlighted inequitable access and outcomes.

Methods

A comprehensive literature review and focus group informed the development of a questionnaire. Topics included non-surgical treatment, opinions on myomectomy and organisation of fibroid services. The online questionnaire was distributed via BSGE newsletter The Scope and at the BSGE ASM in Belfast 2024. Responses were collated and analysis conducted using simple statistics. When considering the availability of treatment options, respondents from the same hospital were grouped together to prevent over representation of services and data were analysed by hospital and grouped per region.

Results

50 survey responses met inclusion criteria, of which 92% were consultant gynaecologists representing 35 different hospitals across the UK. GNRH antagonists were widely available. Myomectomy was offered across all regions, with 82% of respondents performing open and 60% of respondents performing laparoscopic myomectomy. 77% of respondents imposed numerical limits on the number of fibroids they would remove laparoscopically, but only 15% of respondents imposed the same limit for open myomectomy. 93% of respondents would offer a repeat myomectomy, and the length of time patients were advised to wait from surgery to pregnancy varied from under 3 months to over 12 months. 98% of respondents supported a choice of treatment for patients and 94% agreed that access to fibroid care needs a paradigm shift. 90% of respondents supported a multidisciplinary approach to fibroid treatment and 70% felt that fibroid services should be structured similarly to endometriosis or cancer care, with a preference for a hub-and-spoke model (46%) over specialist centres (30%).

Conclusions

The availability of non-surgical treatment modalities such as radiofrequency ablation and GNRH antagonists is promising, however access to minimally invasive myomectomy varies based on fibroid number and the availability of surgical expertise, despite being the gold standard approach in

appropriately selected patients. Our study underscored several evidence gaps that need to be addressed. Only 12% of respondents utilised potential post-operative preventative therapies for fibroid recurrence, and there is no consensus on long term follow up care. This presents an opportunity for future research to explore the benefits of preventative strategies, particularly for women wishing to preserve their fertility. Standardisation of fibroid care is imperative to ensure equitable access.

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Management and clinical outcome of cervical cancer diagnosed in pregnancy: a long-term perspective

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Background

This study aims to describe cervical cancer during pregnancy (CCP), evaluate the clinical outcomes and to discuss the management of CCP.

Methods

We conducted a retrospective review of CCP patients from May 2007 to January 2025 in our institution. CCP patients were divided into two groups: the continuation of pregnancy (COP) group and the termination of pregnancy (TOP) group. Characteristics of these two groups were compared. Survival analyses were performed to assess the impact of clinicopathological factors on prognosis of CCP.

Results

Fifty-four CCP patients (stage IA1 to IVB, 2018 FIGO) were included. Most CCP patients were diagnosed in the first (27.8%) or second (48.1%) trimester. Squamous carcinoma (SCC), adenocarcinoma (AC) and adenosquamous carcinoma (ASC) accounted for 87.0% (47/54) of all the histology types. Pregnancy continued in 46.3% (COP group) and terminated in 53.7% (TOP group) of patients. Most of patients (72.0%) in COP group were diagnosed during the second trimester, whereas patients in the TOP group tended to be diagnosed during the first trimester ($P<0.01$). Additionally, patients in the TOP presented with more advanced stage, and deeper stromal invasion compared to those in the COP group ($P<0.01$). No significant differences were observed between the COP and TOP groups in terms of other demographic and tumour characteristics ($P>0.05$). In the COP group, 10 patients underwent surgeries±neoadjuvant chemotherapy (NACT) including conization, radical trachelectomy and pelvic lymphadenectomy, 9 patients received only NACT and 6 patients postponed the treatments until the delivery. Among all 16 patients who received NACT, an average of 3.31 cycles (range 1-6 cycles) of platinum-based chemotherapy was administrated. Of these patients, 4/16(25%) achieved a complete response (CR) to NACT, 7/16 (43.8%) achieved a partial response (PR), 4/16 (25%) achieved a steady disease (SD), while 1 patient had disease progression (PD). After a mean follow-up of 68.8 months (range 3-215 months), survival analysis revealed no statistically significant differences in recurrence-free survival (RFS) or overall survival (OS) between the COP and TOP groups. The 5-year RFS rate were 81.6% for TOP versus 85.9% for COP, with corresponding 5-year OS rates of 81.0% and 90.5% respectively ($P>0.05$). At the end of the follow-up period (range 4-209 months), 34 children born to CCP patients exhibited normal development.

Conclusions

Pregnancy does not seem to impact cervical cancer prognosis. The oncologic outcomes of the TOP and COP groups were comparable. A pregnancy-preserving strategy could be considered for managing CCP patients.

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Endometriosis of the Canal of Nuck: A Rare Case and Surgical Management

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Background

Endometriosis is characterized by the presence of endometrial glands and stroma outside the uterus. Whereas it most commonly affects the pelvic peritoneum, ovaries, and rectovaginal septum, cases have also been reported in extrapelvic locations. One such rare site for endometrial tissue implantation is the canal of Nuck (patent processus vaginalis). Incomplete obliteration of this canal can create a potential space for endometrial growth. Endometriosis involving the inguinal region is rare, and isolated involvement of the canal of Nuck is even more uncommon. In this report, we present a rare case of endometriosis in the canal of Nuck, which was successfully treated through surgical excision with a minimal skin incision.

Methods

A 32-year-old woman, G1P1, with no history of abdominal or pelvic surgery, presented with a painful, cyclical mass in the right inguinal region. Physical examination revealed a tender lesion between the right inguinal area and the mons pubis. Transabdominal ultrasound showed a 15 x 7.5 mm heterogeneous solid lesion. Surgical excision under general anaesthesia was planned. A 3 cm incision was made lateral to the pubic bone. The lesion was identified within the canal of Nuck, excised with clear surgical margins, and the fascial defect was repaired.

Results

The postoperative course was uneventful. Histopathological analysis confirmed endometriotic foci within fibro-adipose and muscular tissue, with no atypia or malignancy. The lesion was localized accurately using preoperative marking. The patient experienced resolution of symptoms after surgery.

Conclusions

Endometriosis of the canal of Nuck is a rare extrapelvic manifestation that may mimic inguinal hernia or other groin masses. Detailed history, imaging, and surgical exploration are essential for diagnosis. Surgical resection with clear margins and repair of the inguinal canal defect remains the gold standard treatment. Preoperative marking is recommended for small or non-palpable lesions.

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From referral to results: Investigating the patient journey through Outpatient Hysteroscopy

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Background

Outpatient hysteroscopy is a common investigation and treatment modality for gynaecological indications, including postmenopausal bleeding, intermenstrual bleeding, polyps, HRT-related bleeding and menorrhagia. Despite widespread use, there is significant negative publicity, regarding associated pain and patient autonomy. As highlighted in parliamentary debate, some women have described the procedure as "completely unnecessary pain and trauma". Our study aims to explore the experience of the local population with outpatient hysteroscopy, to facilitate meaningful, patient-centred improvements in service delivery and to refine existing patient information resources.

Methods

From February-March 2025, 16 patients were randomly selected from the outpatient hysteroscopy lists of four practitioners. Structured telephone interviews were conducted by a student doctor uninvolved in their care. Interviews took place post-results to minimise anxiety regarding pathology. Transcripts were reviewed by two independent researchers and initial themes were established independently and finalised collaboratively. Data saturation was achieved upon reassessment.

Results

Key themes identified included disparities in pre-procedure information, the impact of practitioner communication, perceived control and post-procedural recovery. Clear, empathetic communication and the ability to pause the procedure were associated with a more positive experience, regardless of pain level. Whereas lack of preparation or unclear expectations heightened anxiety and dissatisfaction. Patients valued environmental comforts (e.g. music, stress balls), and the ability to view the screen. However, there was confusion regarding the procedure's goal or risks, clinic logistics, and distinctions between pelvic ultrasound and hysteroscopy. Variability in patient awareness and use of pre-procedure information were also noted. Although written materials were provided, many had not read them. This highlighted the need for alternative methods, e.g. digital links via SMS. Pain experiences varied widely (0-9). Patients were asked to rate their pain on a scale of 0 (no pain) to 10 (extremely painful), averaging 5.6, with 62.5% reporting mild to moderate pain. These findings are consistent with prior audits, confirming ongoing variation in patient experience despite standardised protocols.

Conclusions

While many tolerated hysteroscopies well, others reported considerable discomfort, often linked to inadequate information or unclear expectations. The main factors influencing experience included the quality of information, referral indication, prior hysteroscopy exposure and expectations. Creating a patient-guided leaflet, including anatomical diagrams, appropriate contacts and additional services, e.g. coil insertions has the potential to reduce anxiety and improve patient

comfort. For those who seek further understanding, reputable online resources should be recommended. Additionally, providing realistic waiting time estimates for non-urgent cases would help manage patient streamline. Changes should be made in collaboration with previous patients to ensure a user-centred approach. Finally, patients consistently valued being treated with empathy and respect. Acknowledging the emotional and physical journey they had made, and maintaining a supportive, friendly approach had a profound impact on how the experience was remembered—often more than the pain itself.

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Primary Uterine Non-Hodgkin B-cell Lymphoma Presenting with Postpartum Bleeding: Successful Management with Chemotherapy and Adjuvant Robotic Hysterectomy - A Rare Case Report.

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Background

Burkitt lymphoma is a highly aggressive B-cell non-Hodgkin lymphoma known for its rapid growth rate. Burkitt lymphoma of the endometrium is extremely rare. When it arises primarily in the endometrium, it presents a unique clinical challenge due to its rarity and the potential for misdiagnosis with more common gynaecological conditions. Because of the limited number of cases, there are no standard treatment guidelines for primary endometrial Burkitt lymphoma. The aggressive nature of this presentation means intensive chemotherapy needs to be commenced immediately. This case report aims to highlight the diagnostic challenges and successful management of this rare entity with chemotherapy and adjuvant hysterectomy.

Methods

A 31 years old lady presented to the gynaecology department with history of ongoing heavy bleeding for 6 weeks following normal vaginal delivery. She was commenced on Tranexamic acid and norethisterone which did not help much. An ultrasound scan was performed which was suggestive of retained products of conception. She underwent hysteroscopic guided surgical evacuation of retained products. Histological analysis of the evacuated tissue revealed primary endometrial high-grade B-cell Non Hodgkin lymphoma, likely Burkitt lymphoma. Following the diagnosis, an urgent referral was made to Haematology. CT scan at diagnosis showed the disease to be confined to the uterus with bulky disease. The significant risk of bleeding or potential uterine rupture with the initial cycle of chemotherapy was discussed with the patient given the rapid rate of growth of the tumour and rapid breakdown. She tolerated her chemotherapy really well and after 2 – 3 weeks the excessive bleeding lessened, and the pelvic mass shrunk considerably in size. The post treatment Positron Emission Tomography (PET) scan showed a complete remission and a normal sized uterus. As she had completed her family, she was keen to have a hysterectomy instead of a radiotherapy to avoid radiotherapy associated side effects. Her case was discussed in the MDT and an MRI was performed for surgical planning. She underwent robotic hysterectomy with conservation of the ovaries in the oncology centre.

Results

The patient achieved complete remission after chemotherapy. The subsequent robotic hysterectomy with ovarian conservation was performed successfully. Postoperative recovery was uneventful, and the patient remains under regular haematological follow-up with no evidence of disease recurrence.

Conclusions

This case underscores the diagnostic pitfalls of primary endometrial B-cell lymphoma, where initial presentation and even endoscopic findings can be misleading, mimicking common gynaecological issues like postpartum complications. Successful management with chemotherapy followed by

adjuvant robotic hysterectomy with ovarian preservation demonstrates a potential treatment strategy for this rare malignancy, emphasizing the importance of thorough histological evaluation of endometrial samples obtained during gynaecological procedures.

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Metachronous bilateral ovarian carcinomas of distinct histology in a young woman: a case of endometrioid and high-grade serous carcinoma

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Background

Metachronous bilateral ovarian carcinomas with differing histologic subtypes are exceedingly rare, and current literature provides limited guidance on treatment protocols. We report a case involving the sequential development of endometrioid and high-grade serous carcinoma in a young woman to highlight diagnostic and therapeutic challenges.

Methods

A 31-year-old patient was diagnosed in July 2023 with FIGO stage IA, grade 1 endometrioid adenocarcinoma of the left ovary. She underwent fertility-preserving surgery with surgical staging; no adjuvant therapy was indicated. In February 2025, during routine surveillance, a suspicious lesion on the right ovary was identified. Having completed childbearing (three children), fertility preservation was no longer a consideration. A laparoscopic right adnexectomy was performed at a local hospital. The patient was subsequently referred to our institution, where robotic-assisted completion staging surgery was conducted, including hysterectomy, bilateral pelvic and para-aortic lymphadenectomy, and omentectomy.

Results

Histopathological examination, performed both at the local hospital and at our institution, revealed a microinvasive high-grade serous carcinoma of the right ovary (FIGO stage IA) with intact capsule and no evidence of metastatic spread. Postoperative recovery was uneventful. Given the tumour's aggressive histology, six cycles of adjuvant platinum-based chemotherapy were recommended. Germline genetic testing revealed no pathogenic variants. The patient remains in good clinical condition and has provided written informed consent for this presentation.

Conclusions

This case underscores the necessity for sustained oncologic follow-up in young ovarian cancer patients, even when initial disease appears low risk. The metachronous development of two histologically distinct ovarian carcinomas highlights the need for short-interval follow-up, individualized treatment planning, and strict adherence to comprehensive staging and adjuvant therapy protocols.

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Non-invasive visualization of ureter with indocyanine green (ICG) during gynaecological laparoscopy

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Background

Ureteral injuries are significant complications that can arise during laparoscopic surgical procedures. Traditional identification is visual only and may be challenging in distorted anatomy. The incidence of iatrogenic ureteral injuries (IUIs) in gynaecological surgeries varies between 0.013% and 1.8%, with hysterectomies being the most common cause. Intraoperative iatrogenic ureteral injuries represent rare technical surgical complications with the potential for adverse patient outcomes. Delayed diagnosis significantly increases the likelihood of nephrectomy, with rates rising from 10% to 60%. Visualization of ureters with indocyanine green (ICG) during laparoscopy is an emerging technique aimed at reducing the risk of ureteral injury in minimally invasive pelvic surgeries. ICG fluorescence imaging enables real-time visualization of ureters using near-infrared (NIR) light.

Methods

Case presentation: A 77-years-old female patient underwent robot-assisted laparoscopic total hysterectomy combined with sacrocolpopexy for the treatment of symptomatic uterine prolapse and uterine leiomyoma. The procedure was indicated due to stage II pelvic organ prolapse and a symptomatic fibroid causing pelvic pressure. The patient had normal eGFR value. The operation was performed utilizing the Da Vinci robotic surgical system (Intuitive Surgical, Sunnyvale, CA).

Results

Following intravenous administration of indocyanine green (Verdye, Diagnostic Green Ltd.) at a dose of 0.3 mg/kg body weight, the visibility of the ureters was assessed at 15, 30, 45, and 60 minutes. During the arterial phase (first 1–3 minutes), small vessels accompanying the ureters became visible. The course of the ureter was most clearly visualized at 45 minutes post-injection. The interpretability of the imaging may be significantly affected by ICG extravasation or pooling. As ICG is exclusively excreted by the liver, at least 30 minutes are required for its appearance in the urinary tract in the absence of forced diuresis. Compared to retrograde ICG instillation, intravenous administration demonstrates lower sensitivity for ureteral identification.

Conclusions

Intravenous application of indocyanine green for ureteral identification during gynaecologic laparoscopic surgery is a feasible and usable method. Although its sensitivity is inferior to that of invasive techniques and it is more time-consuming, it may be recommended in cases where invasive options are unavailable.

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A review of complications following elective gynaecological surgery in a district general hospital

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Background

In response to challenges posed by the COVID-19 pandemic, the Trust relocated elective gynaecological surgeries to a non-acute site to establish a 'green pathway' and minimise infection risks. This presented challenges in managing post-operative complications due to an absence of the specialist gynaecology team on-site. To address this, the Trust adopted a low threshold for transferring patients to the acute site if recovery was not as expected.

Our review aimed to evaluate whether complications following elective gynaecological endoscopic procedures were promptly identified and effectively managed, ensuring patient care remained uncompromised by the dual-site model.

Methods

A retrospective cohort review was conducted for 29 months (April 2022–September 2024) at a district general hospital. Incident reports were analysed to assess associated complications. Data were collected from electronic patient records. Data extracted included patient demographic, comorbidities, procedural details, post operative complications, transfer to the main hospital, return to theatre, surgical outcome, and length of inpatient stay.

Results

There were 1907 cases of elective gynaecological endoscopic procedures performed during the study period. The most common procedures performed were hysteroscopy and biopsy (n=764), diagnostic laparoscopy (n=255), and operative hysteroscopy (n=188). Procedures with associated complications included total laparoscopic hysterectomy (TLH) (n=3), diagnostic laparoscopy (n=3), hysteroscopy and biopsy (n=2), laparoscopic salpingo-oophorectomy (n=2), and robot assisted TLH (n=1).

A total of 11 patients had reported complications, of which five patients required return to theatre, three within the elective admission, and two upon readmission. Four out of 11 patients were planned day-cases that required conversion to unplanned inpatient stay due to a complication. Four cases required transfer to the acute site within the elective admission, all of which were achieved within 24 hours from identification, with escalation documented. Three patients required return to theatre within the elective admission, and all were successfully managed without adverse outcomes.

Conclusions

The complication rates for elective gynaecological endoscopic procedures were consistent with reported literature. Operating at a separate site did not compromise patient safety while allowing increased elective operating capacity. Overall, this study supports the continuation of elective gynaecological endoscopic surgery at a non-acute site, provided robust escalation mechanisms and adequate inpatient capacity remain in place.

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Fluorescent Coated Devices

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Background

The great evolution near infrared laparoscopic cameras in the last years improves our visualization allowing us to see far and beneath structures.

Better identification of surgical planes and landmarks enhance our precision and reduces morbidity. In the market we have some high cost disposable devices with passive fluorescent capabilities to help in vaginal or rectal/sigmoid steps during surgeries.

With a safe, fast, simple and low cost technique we could coat endoluminal devices like uterine manipulator, vaginal and rectal probes, circular staples and others to be seen with fluorescent techniques during laparoscopic surgeries.

Methods

Minutes before the surgery the border of endoluminal device was painted with fine mixture of Indocyanine Green Dye and Surgical Glue and wait to be dried.

The specific endoluminal device was inserted depending on the case and listed below.

Devices: disposable uterine manipulators for colectomy during hysterectomies;

Circular staplers for sigmoidectomies and discoid resections in endometriosis surgeries

Vaginal / rectal probes in endometriosis nodule affecting the rectal-vaginal space.

During the surgery the fluorescent overlay mode was turned on, as desired, and the contrast of the endoluminal coated device was shown, improving the visualization.

Results

This technique was used in 47 hysterectomies to improve the colpotomizer visualization - disposable uterine manipulator.

6 Discoid endometriosis discoid resections - circular stapler.

5 Sigmoidectomies due to endometriosis - circular stapler.

18 Endometriosis of uterosacral ligaments - probe inside vagina.

12 Endometriosis of rectal-vaginal space - probe inside rectum / sigmoid.

In all procedures the improved visualization of the borders of the endoluminal device help identifying surgical planes.

No complications concerning the devices were recorder

Conclusions

The enhance visualization of endoluminal device borders facilitate surgical planes identification helping int he surgeries

No complications due to the technique were noted.

This safe, fast, simple and low-cost technique could be applied in numerous varied endoluminal devices enhancing surgical visualization.

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Evaluating the Jing Method: Effects of Advanced Clinical Massage on Pain and Quality of Life in Women with Endometriosis and Adenomyosis

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Background

To evaluate the efficacy of advanced clinical massage "The Jing Method", a multi-modality treatment approach for chronic pain that combines Eastern and Western bodywork techniques, on pain levels and health-related quality of life (HRQoL) in women with endometriosis and adenomyosis.

Methods

A prospective study design was conducted involving 12 women with a confirmed diagnosis of endometriosis and/or adenomyosis, of which 9 completed the study. Following a 6-week control phase, participants underwent a 6-week intervention period where they received weekly 60-minute clinical massage treatments based on The Jing Method protocol, alongside prescribed self-care routines. Pain and HRQoL were assessed using validated outcome measures: Pain Outcome Questionnaire–Short Form (POQ-SF), Endometriosis Health Profile–30 (EHP-30), and the British Society for Gynaecological Endoscopy (BSGE) Pelvic Pain Questionnaire at baseline, post-intervention, and at 4-week follow-up.

Results

Significant improvements were observed across all measured outcomes. A 36% reduction in EHP-30 pain score was observed during the intervention period with a further 7% reduction at follow up on week 16. Similarly, POQ-SF total pain scores observed a reduction of 33%. BSGE outcomes reflected a reduction in menstrual pain, pre-menstrual pain and non-cyclical pain of 34%, 33% and 38% respectively. Enhancements were also seen in bladder and bowel function with both domains reducing from moderate to mild on the validated scale. Beneficial reduction in "loss of control", "powerlessness", negative self-image and negative emotional wellbeing were also observed, highlighting the psychological burden of these conditions. Findings across all 3 questionnaires reflected immediate benefits of the intervention along with highlighting the sustained effects of treatment with continued improvements in lifestyle and pain scores 4 weeks' post intervention

Conclusions

The Jing Method of advanced clinical massage provides an effective non-invasive complementary therapy for managing pain and improving HRQoL in women with endometriosis and adenomyosis. These findings highlight the potential role of integrated, biopsychosocial, and multimodal approaches in the supportive management of these chronic gynaecological conditions along with the role of empowering women in their understanding of their pain and managing their conditions.

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Diagnosis and treatment of concurrent transverse vaginal septum and complete uterine septum : a rare case report

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Background

A transverse vaginal septum is a rare anomaly of the female reproductive system, and its coexistence with a complete uterine septum is an exceptionally uncommon finding. The condition develops due to incomplete resorption following the fusion of the Müllerian ducts with the urogenital sinus. In cases of complete vaginal septum, menstrual blood accumulates behind the obstruction, leading to hematocolpos, hematometra, and cyclical abdominopelvic pain, whereas partial septa more commonly present with symptoms such as dyspareunia and dysmenorrhea. Here we present the diagnosis and treatment of concurrent transverse vaginal septum and complete uterine septum in a patient, who presented to seek assistance for conception.

Methods

Our patient is 23 years old female and married for 2 years. She was referred to our clinic due to dyspareunia and difficulty conceiving. Physical examination revealed normally developed secondary sexual characteristics. A 3–4 cm blind-ending vaginal canal was observed, with menstrual blood emerging from a pinpoint opening at the 1 o'clock position. Ultrasonography revealed fluid collection between the vaginal septum and cervix, along with a complete uterine septum extending from the cervix to the uterine fundus. Additionally, a 10 mm polyp was identified in the left hemicavity. Both ovaries and paraovarian areas appeared normal. Surgical treatment was initiated with an incision at the septal ostium, creating a vaginal opening and restoring patency. Once the cervix was reached, the uterine septum was resected using a resectoscope, and the polyp was removed. To prevent postoperative adhesions, hyaluronic acid gel was applied to the uterine cavity. A detailed description of the diagnosis and surgical procedure is presented in the video.

Results

The total operative time was 50 minutes. No early postoperative complications were observed. At the one-month follow-up, the vagina appeared to have a normal width, and a single uterine cavity was visualized.

Conclusions

The diagnosis of concurrent transverse vaginal septum and complete uterine septum requires careful evaluation. Hysteroscopy offers an effective and minimally invasive alternative to conventional treatment approaches.

<https://player.vimeo.com/video/1084540521?autoplay=1>

Innovative tubal cannulation technique for low-resource settings

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Background

Tubal factor infertility accounts for a significant share in the distribution of causes of infertility. Traditionally, Assisted Reproductive Technology (ART) has been deemed the only solution for such cases. However, on more scrutiny, ART has been assigned to proximal tubal obstruction, while distal tubal blockage was allowed a chance at tubal surgery, primarily laparoscopic.

On a step further, there has been trials to treat proximal tubal obstruction through Hysteroscopic cannulation techniques. However, such procedures often require high levels of technical skills and have a potential for tubal injury and complications. Furthermore, the specialized sets needed for such procedures are often expensive, and unaffordable in low and medium-resource settings.

Methods

We hereby present an innovative technique that we have developed, tried, and improved in our centre, where readily-available tools, which are also available at low and mid-income settings, are used.

This affordable setup proved effective, through Hysteroscopic approach, in negotiating proximal tubal obstruction, opening a window of hope for infertile couples with this type of tubal factor infertility.

Results

This affordable setup proved effective for proximal tubal blockage, not only proved by tubal patency tests, but through helping a large series of patients achieve spontaneous pregnancy, as observed in our case series follow up.

Furthermore, there were no recorded complications from this minimally invasive procedure.

Conclusions

Hysteroscopic tubal cannulation can be an effective treatment for selected cases of tubal factor infertility. It has the added benefit of avoiding the high cost and potential complications of ART, in addition to a long-lasting effect.

A new affordable, simple, and safe technique is proposed for use due to its efficacy and availability, which is particularly suitable for low- and medium-income settings.

We hope this could expand the use and implementation of this simple Hysteroscopic procedure to improve the reproductive potential of infertile couples with proximal tubal disease.

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Enhanced Recovery After Surgery Protocols in Deep Infiltrating Endometriosis Surgery: A Systematic Review and Meta-Analysis of Perioperative Outcomes.

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Background

Surgery for deep infiltrating endometriosis (DIE) is technically demanding and often associated with significant postoperative morbidity. Optimizing perioperative care is crucial for improving patient outcomes. This meta-analysis aimed to compare the effectiveness of Enhanced Recovery After Surgery (ERAS) protocols versus conventional perioperative management in women undergoing surgery for DIE.

Methods

A systematic literature search was conducted in Medline, Scopus, Google Scholar, Cochrane CENTRAL, and ClinicalTrials.gov from inception to August 2024. Eligible studies included comparative cohorts evaluating ERAS versus standard care in DIE surgery. Meta-analysis was performed using RevMan 5.4 (The Cochrane Collaboration, Copenhagen), applying a random-effects model. Outcomes were summarized as mean differences (MDs) for continuous variables and odds ratios (ORs) for dichotomous variables, with 95% confidence intervals (CIs). Study quality was assessed using the ROBINS-I tool for non-randomized studies and RoB-2 for randomized controlled trials.

Results

Four studies were included, encompassing a total of 1,662 patients undergoing surgery for DIE. ERAS protocols were associated with a significant reduction in the duration of postoperative hospitalization (MD -2.88 days; 95% CI: -5.34 to -0.41; $p = 0.02$). No significant differences were observed in hospital readmission rates between the ERAS and control groups (OR 1.13; 95% CI: 0.75–1.73; $p = 0.55$). Similarly, the incidence of minor complications (Clavien-Dindo grade I–II) (OR 0.75; 95% CI: 0.49–1.16; $p = 0.20$) and major complications (grade III or higher) (OR 0.60; 95% CI: 0.27–1.33; $p = 0.21$) did not differ significantly between groups.

Conclusions

The implementation of ERAS protocols in DIE surgery appears to significantly shorten hospital stay without increasing postoperative complications or readmission rates. These findings support the use of ERAS pathways in complex gynaecologic surgery. Nevertheless, larger high-quality randomized trials are needed to further validate the benefits and safety of ERAS in this specific patient population.

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Delayed diagnosis and conservative management of bladder injury following retropubic tension-free vaginal tape (TVT) surgery: A case report

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Background

Tension-free vaginal tape (TVT) surgery is a commonly performed and generally safe procedure for treating stress urinary incontinence. However, bladder injuries may still occur and can occasionally present in a delayed fashion. Routine cystoscopy is recommended to rule out bladder injury; however, the type of scope and angle of optics play a critical role in detecting small or valve-like perforations. Bladder perforations can still be missed when visualization is suboptimal, particularly in anterior or dome regions of the bladder. We present a case in which bladder injury was missed intraoperatively due to limited optics and later confirmed using methylene blue instillation and repeated cystoscopy. The case also demonstrates a novel selective tape excision technique aiming to preserve continence function while resolving the complication.

Methods

A 39-year-old woman (G4P4) with pure stress urinary incontinence and a history of three caesarean sections underwent a retropubic TVT operation. Due to lack of access to urological 30° or 70° optics, intraoperative cystoscopy was performed using a 12° hysteroscope. No bladder injury was identified, and the procedure was completed. Postoperatively, the Foley catheter was removed after 6 hours, and the patient voided spontaneously. Within 24 hours, she presented with leakage of clear fluid from the suprapubic incision. Bedside ultrasound revealed no free intraabdominal fluid. Methylene blue dye was instilled via a reinserted Foley catheter, and blue-stained fluid was observed emerging from the upper abdominal incision, indicating bladder perforation. A second cystoscopy using the same 12° hysteroscope, this time with full bladder filling, revealed a defect on the left side of the bladder.

Results

The patient was discharged 6 hours after the corrective surgery. On postoperative day 5, she reported dysuria but had no fever or abdominal pain. CRP was elevated to 230 mg/L. A urinary tract infection was suspected, and empirical antibiotics were initiated. No further complications occurred. On day 17, CRP returned to normal. The Foley catheter remained in place for 10 days. She was continent and symptom-free at 3- and 6-month follow-up.

Conclusions

Bladder injury following TVT surgery may present with subtle signs and should be suspected when unusual drainage occurs. In cases with limited intraoperative visualization, postoperative dye testing and repeat cystoscopy are valuable. Conservative surgical techniques can be effective in managing complications while maintaining continence.

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There's always a chance!

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Background

Vital and healthy endometrium is crucial for achieving and maintaining pregnancy. Several events may lead to destruction and damage of this velvety lining of the uterus, including excessive curettage, various infections, and iatrogenic factors following surgical procedures involving the endometrial cavity.

The end point of such injuries lead to various degrees of loss of endometrial tissues, and formation of intra-uterine synechia (IUS), resulting in different grades of Asherman's syndrome.

Methods

Hysteroscopic diagnosis and consequent management of intra-uterine synechia is the gold standard strategy for dealing with intra-uterine synechia. These can be cut either by hysteroscopic scissors, or through the use of energy-based instruments.

However, hysteroscopists often feel disappointed with the results of such interventions, especially that the patients usually need frequent sessions, where the reformation of adhesions of encountered.

Even with the introduction of novel approaches to help the endometrium recover and prevent re-adhesions, such as different types of barriers, platelet-rich plasma (PRP), and stem cell therapy, results may still seem unpromising.

This delay in reaping the fruits of interventions, has led many hysteroscopists to feel helpless in the face of this problem, and even abandoning these procedures.

We, through reporting a large series of cases we have managed and followed up over many years, hope to raise the hopes of both patients and our fellow surgeons, on the outcomes of hysteroscopic interventions for intra-uterine synechia.

Results

Despite the initial off-putting appearance of the occluded uterine cavities, and the depressing look of the lost and fibrosed endometrium, and additionally the need for several sessions of hysteroscopic adhesiolysis, the outcome of many cases of Asherman's syndrome is eventually worthwhile.

In our experience with many such cases with severe IUS, over several years, with long-term follow up, we have seen many patients who resumed menstruation after years of secondary amenorrhea. We have even records of patients who achieved pregnancy. Although some of these pregnancies terminated early by miscarriage, still many cases managed to carry on till term or near term.

Conclusions

We hope to deliver a message of support and hope to both patients and colleagues facing the challenges of intra-uterine synechia. Perseverance with multiple sessions of hysteroscopic adhesiolysis, early re-do, and keeping high morale, eventually pays off in many cases.

Furthermore, novel developments, such as adhesion prevention barriers, PRP, and stem cell therapy, though not yet gaining consensus approval of solid value, may be of help to such patients in the near future.

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Caesarean Scar Endometriosis: The Critical Role of Early Diagnosis and Surgical Excision – A Case Report

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Background

Caesarean scar endometriosis (CSE) is a rare but increasingly recognised form of extrapelvic endometriosis that develops at the site of previous caesarean section incisions and occurs in 0.03–0.45% of post-Caesarean patients (1). It is characterised by the presence of ectopic endometrial tissue in surgical scars and has garnered increased attention due to rising global caesarean section rates (2). If diagnosis is delayed, it can cause unnecessary health problems and may be wrongly identified as hernias, abscesses, or tumours; getting treatment on time can lower the chances of it coming back and reduce related health issues. This case highlights diagnostic challenges and management strategies for CSE.

Methods

A 34-year-old multiparous (Para 4) woman with a history of emergency caesarean section presented to the gynaecology clinic with a nine-month history of a painful, palpable 2 cm lump at the right edge of her previous transverse caesarean section scar. There was no overlying skin change or discharge. An abdominal ultrasound demonstrated a heterogeneous, hypoechoic lesion within the subcutaneous fat layer, measuring 23 × 16 × 21 mm, featuring scattered hyperechoic foci and cystic components without overt vascularity. Given the suspicion of scar endometriosis, a therapeutic trial of the GnRH analogue leuprorelin was initiated, which led to the complete resolution of the patient's symptoms following her second dose. This dramatic response to hormonal suppression provided strong clinical support for the diagnosis of scar endometriosis. She chose to undergo surgical excision under general anaesthesia. Intraoperatively, a local excision of a 2 cm nodule from the right margin of the caesarean scar was performed. The lesion and the abdominal wall were removed en bloc because endometriotic tissue had also developed in the rectus abdominis muscle and sheath. Histopathological analysis confirmed the diagnosis: it showed a mix of fat and muscle tissue with numerous glands similar to those in the uterus, surrounded by supportive stroma, along with some cysts, cellular changes, and iron deposits—findings consistent with endometriosis and without signs of malignancy. At her three-month postoperative review, the patient reported complete resolution of the cyclical pain and tenderness at the scar site.

Results

-

Conclusions

The diagnosis of CSE presents challenges due to its relative rarity and the non-specific nature of many of its symptoms. CSE requires a high index of suspicion, particularly in patients with cyclical pain post-caesarean. Medical management with GnRH analogues can aid diagnosis, but surgical excision with clear margins is widely regarded as the gold standard treatment for CSE (3). This case aligns with the literature, emphasising the importance of histopathological confirmation and timely intervention (4–6).

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Hysteroscopic Resection of Cervical Ectopic Pregnancy: A Case Report

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Background

A 37-year-old G0P0A0 patient presented with a history of amenorrhea and a positive urine pregnancy test. Ultrasound examination revealed an empty endometrial cavity. However, a gestational sac containing a viable embryo was located in the cervical canal. Serum beta-human chorionic gonadotropin (hCG) level resulted 6444 mIU/ml. The patient was asymptomatic.

Methods

A single intramuscular dose of 100 mg methotrexate was administered. Weekly hCG measurements were conducted. hCG decreased to 4343 mIU/ml after two weeks. The patient experienced transient minor bleeding. A follow-up ultrasound confirmed the presence of the cervical gestational sac with a developing embryo, but without a heartbeat. The patient declined a second dose of methotrexate and opted for observation.

Despite experiencing two additional episodes of bleeding, hCG levels did not decline further, and ultrasound findings remained unchanged. After discussing the case with the patient and obtaining her consent, hysteroscopy, with a 5-mm Bettocchi scope, was performed under sedation. The pregnancy was visualised within the cervical canal. The gestational sac was successfully excised using cold scissors and grasping forceps. Minor bleeding was encountered at the site of excision. A Foley was placed in the cervical canal.

Written informed consent for the publication of these details was obtained from the patient.

Results

The patient was discharged 24-hours post procedure. Normal menstrual cycles resumed after 5-weeks.

Currently, the patient is 32-weeks pregnant.

Conclusions

Hysteroscopic resection of cervical ectopic pregnancies represents a viable alternative for uncomplicated cases where medical treatment has failed.

Missed Opportunities: Fertility, Follow-Up, and Fulfilling NICE Guidelines in Endometriosis Care

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Background

Endometriosis is a chronic inflammatory condition frequently associated with delayed diagnosis and a significant impact on quality of life. Symptoms vary widely, and complex cases are often referred to gynaecology, fertility services, or specialist endometriosis centres for multidisciplinary care. Improving diagnostic and management pathways is crucial, as delays can worsen outcomes. Treatment options—conservative, pharmacological, or surgical—are tailored to each patient. This study aimed to evaluate diagnostic timelines and adherence to NICE guideline NG73, with a focus on the management of patients prioritising fertility.

Methods

A retrospective review was conducted using electronic health records of 50 patients who underwent diagnostic laparoscopy for suspected endometriosis at a district general hospital in South London. Data collected included the interval from initial consultation to surgery, imaging modalities used, intraoperative findings, and post-operative management plans. This analysis aimed to evaluate departmental compliance with national guidelines and best practices for the diagnostic and management pathway.

Results

The mean interval from first consultation to diagnostic laparoscopy was 182 days, with a maximum wait of 920 days. Imaging was completed or offered in 89.5% of cases: transvaginal ultrasound (TVUS) in 74%, MRI in 6%, and both in 8%. Referral to pain management was absent in 94% of cases, and no patients had access to an endometriosis nurse. Fertility discussions were lacking in 78% of cases. Among patients expressing a desire for fertility support, only 10% were referred to fertility services, with 8% receiving input; 2% were deemed ineligible due to high BMI.

Conclusions

While surgical management within the department broadly aligns with NICE guideline NG73, significant gaps remain in holistic care provision. However, several areas require improvement, including timely discussions around fertility, access to specialist support (e.g. endometriosis nurse), reduction in waiting times for surgery, and the establishment of clear and consistent follow-up plans. Many of these challenges reflect systemic issues, namely the lack of funding for a gynaecology pain team and endometriosis nurse specialist. Addressing these gaps is essential to delivering more holistic and patient-centred care for individuals with endometriosis. In order to begin to bridge the gap and provide better care we are endeavouring to develop a patient-initiated follow-up (PIFU) pathway for post-operative cases, building on successful models trialled in other departments in the hospital.

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Short-Term Safety of Dienogest on Bone Mineral Density in Iranian Women with Endometriosis: A Cross-Sectional Study

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Background

Dienogest (DNG), a fourth-generation progestin, is widely used in the medical management of endometriosis due to its effectiveness in reducing pain, preventing recurrence, and improving quality of life. However, concerns remain regarding potential side effects, particularly its impact on bone mineral density (BMD). This study aimed to evaluate the short-term safety and efficacy of DNG (2 mg daily for 24 weeks) in Iranian women with endometriosis.

Methods

In this cross-sectional study, lumbar and pelvic BMD were measured before and 24 weeks after initiating DNG treatment. Pain severity related to dysmenorrhea and dyspareunia was assessed using a visual analog scale. Statistical analyses included paired t-tests and chi-square tests to compare pre- and post-treatment values.

Results

A total of [insert sample size] women with a mean age of 35.42 ± 4.76 years were included. Treatment with DNG led to a significant reduction in dysmenorrhea and dyspareunia ($P < 0.001$). Overall pelvic and vertebral BMD remained stable, except for a significant reduction in BMD at L1 (from 0.37 ± 0.96 to 0.22 ± 0.89 ; $P = 0.01$).

Conclusions

DNG at a dose of 2 mg daily for 24 weeks appears to be a safe and effective option for the treatment of endometriosis, with minimal impact on bone mineral density. It significantly alleviates pain symptoms, particularly dysmenorrhea and dyspareunia, in the short term.

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Ultrasound-guided uterosacral ligament anesthetic block

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Background

The anatomic basis for the uterosacral ligament (USL) block is that the upper vagina, cervix, and lower uterus are innervated by the uterovaginal (or Frankenhäuser) plexus, which contains fibres derived from the inferior hypogastric (pelvic) plexus (T10-L1) and sacral nerve roots (S1-S4). Physical pain originates from the S2 to S4 parasympathetic fibres that innervate the cervix and the lower part of the uterine body. Injection of local anaesthetic around the cervix anaesthetizes the second to fourth sacral nerve roots as they pass through Frankenhäuser's plexus at a depth of 2 to 4 mm. We aimed to evaluate whether performing a uterosacral block with an ultrasound-guided technique can improve the symptoms of patients suffering from dysmenorrhea and dyspareunia.

Methods

We recruited 15 patients suffering from dysmenorrhea and dyspareunia aged between 18 and 33 years old with selective tenderness over the USL, but without apparent pathology such as deep endometriosis (DE) on ultrasound. We asked all patients to quantify the pain with a score from 1 to 10 while applying pressure with the transvaginal probe on the right and left USL. The ultrasonographic technique to visualize the USL was, after having visualized the uterus longitudinally, rotating the probe by 90 degrees to visualize the cervix in transverse plane. Subsequently, we visualized the uterine vessels using Power Doppler and, caudally we identified the hyperechoic USL. Subsequently, under general anaesthesia, using a transvaginal ultrasound probe guide with a 20Gx200 mm needle, we injected Solumetrol 20mg, lidocaine 1% and Ropivacaine 0.25% at the insertion of the USL with the cervix. Patients were asked for their pain score according to the technique described above, 4 hours, 2 days, 1 week and 1 month after surgery.

Results

The median pain scores before injection and 4 hours, 2 days, 1 week and 1 month after the procedure were 8,3 (range 7-10), 1,0 (range 0-3), 3,5 (range 0-7), 5,0 (range 2-10), and 5,9 (range 2-10) respectively. All patients showed a resolution of symptoms in the following 48 hours after injection. After 1 month, five patients reported notable resolution of symptoms with a pain score lower than 4. The others showed the reappearance of the painful symptoms but with a pain score lower than that before the injection.

Conclusions

Ultrasound-guided uterosacral ligament anesthetic block appeared to be a good minimally invasive technique for, at least short term pain relieve in patients with dysmenorrhea and dyspareunia with selective tenderness on the USL, but without DE. Furthermore, it might be a valid diagnostic test triaging those patients who might benefit from laparoscopic uterosacral resection. Prospective randomized double-blind studies are needed to prove this hypothesis.

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Advantages of robot-assisted laparoscopy in the treatment of urinary tract endometriosis

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Background

Endometriosis is a chronic gynaecological disease characterized by the spread of tissue similar to the uterine mucosa beyond its normal location. One of the most rare and difficult to diagnose variants of endometriosis is the lesion of the urinary system, in particular, the bladder and ureters.

One of the minimally invasive accesses in the treatment of urinary tract endometriosis (UTE) is robot-assisted, providing the surgeon with the best tissue visualization and precision manipulation capabilities to date.

The aim of our study was to prove the advantages of robot-assisted laparoscopy over other methods of surgical treatment of urinary tract endometriosis.

Methods

We compared robot-assisted laparoscopy with classical laparoscopy. Criteria such as operative time, age of the patients, postoperative complications, and hospital stay were analysed in detail.

Results

In the period from 2020 to 2024 Moscow Regional Scientific Research Institute of Obstetrics and Gynaecology named after V.I. Krasnopol'sky had 33 patients with UTE of the urinary system were operated on. Of them 8 operations were performed with the help of the Da Vinci robotic system, and 25 operations were performed with the traditional access. The average age of the patients was 35 years. The average time of robot-assisted laparoscopy surgery was 153 minutes, while the average time of classical laparoscopic surgery was 127 minutes.

There were no complications that occurred during Da Vinci robot-assisted surgery. And after classical laparoscopy two patients had such complications as peritonitis and ureteral stricture, decrease of left kidney function less than 20%.

The number of days of patients' stay from the moment of operation to discharge from the hospital did not differ significantly.

Conclusions

Despite a slight increase in operative time, robot-assisted laparoscopy demonstrates comparable results to classical laparoscopy in the treatment of urinary tract endometriosis, while providing potentially higher accuracy of surgical manipulation and improved quality of life after surgery.

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Clinical Course and Treatment of Atypical Polypoid Adenomyoma Confirmed by Hysteroscopy: A Case Report

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Background

Atypical polypoid adenomyoma (APA) is a rare benign uterine tumour characterized by a biphasic proliferation of atypical endometrial glands and smooth muscle stroma. Although considered benign, APA carries a significant risk of recurrence and a possible association with atypical endometrial hyperplasia or well-differentiated endometrial carcinoma. It most commonly affects women of reproductive age and may present with abnormal uterine bleeding, infertility, or be detected incidentally during imaging or diagnostic procedures. This case report aims to present the diagnostic approach, clinical course, and conservative treatment of APA confirmed by hysteroscopy in a patient undergoing infertility evaluation.

Methods

Patient undergoing diagnostics for primary infertility was found to have a submucosal uterine lesion measuring three centimetres during a transvaginal ultrasound examination. Based on the diagnosis of a submucous myoma, hysteroscopic evaluation and resection were indicated. The procedure was performed under general anaesthesia, and complete resection of the lesion was achieved. Histopathological analysis revealed the diagnosis of atypical polypoid adenomyoma.

Results

The patient underwent regular six-month follow-up hysteroscopy. At a control hysteroscopy, performed after the histopathological report, a recurrence of the lesion was confirmed through targeted biopsy. Given the patient's age and reproductive goals, as well as the histological confirmation of recurrence, the case was presented to the Oncology Board at the Institute of Oncology of Vojvodina in Sremska Kamenica. The decision was made to pursue conservative management with a second hysteroscopic biopsy of the recurrent lesion, followed by placement of a levonorgestrel-releasing intrauterine device (IUD), Mirena. This approach aimed to reduce the risk of further recurrence while preserving fertility.

At a follow-up hysteroscopy six months after the second procedure, no signs of disease recurrence were noted. The patient remained asymptomatic and was referred back to Human reproduction department for further infertility treatment. She subsequently underwent two IVF-ICSI cycles, after which pregnancy was successfully achieved.

Conclusions

Hysteroscopic resection represents both a diagnostic and therapeutic cornerstone in the management of APA. In women desiring fertility preservation, conservative treatment with progestin-releasing IUDs may be considered as an adjunct to surgical resection. Careful

histopathological evaluation, close monitoring, and multidisciplinary management are essential to reduce the risk of recurrence and prevent potential malignant progression.

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Comparison of the effects of hysterectomy routes on ovarian reserve, ovarian doppler and sexual function in salpingectomy added to hysterectomy

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Background

The most common procedure in the operative gynaecology is the hysterectomy which is performed with various indications and via several different routes. Considering the pathogenesis of epithelial ovarian cancer, addition of salpingectomy to hysterectomy in the low-risk group for ovarian cancer is now the primary risk-reducing method used in gynaecology practice. There is no clear consensus on the effect of salpingectomy on ovarian reserve in previous studies. In this study, it was planned to compare the effects of different hysterectomy routes on ovarian reserve, ovarian doppler and sexual function in salpingectomy added to hysterectomy.

Methods

A total of 46 patients who were planned to have hysterectomy operation due to benign gynaecologic conditions were included in the prospectively designed study after their informed consent was obtained. The patients were evaluated with Anti-müllerian hormone (AMH), Female Sexual Function Index (FSFI) questionnaire and ovarian doppler preoperatively and at the 3rd month postoperatively and only with AMH and ovarian doppler at the 1st month postoperatively. Comparisons between and within groups were made according to the route of hysterectomy.

Results

Baseline demographic and clinical characteristics were similar between the groups in t. There was no significant difference in AMH values in the 1st and 3rd months in the laparoscopy (L/S) group (0.15(0.01:2) ng/ml-0.09(0.01:1.57) ng/ml-0.16(0.01:2.51) ng/ml). A significant difference was found in the 1st month in the Laparotomy (L/T) group ($p=0.043$); however, no significant difference was found at 3rd months (0.1(0.01:3.4) ng/ml-0.05(0.01:2.82) ng/ml-0.07(0.01:3.5) ng/ml). When the two groups were compared, no significant difference was found between the changes in AMH in the 1st and 3rd months. In FSFI scores, a significant difference was found in the increase in sexual desire, arousal, and total scores in L/S group ($p=0.023$ - $p=0.028$ - $p=0.025$ - $p=0.033$). A significant difference was found in the increase in sexual desire, lubrication, pain, and total scores in L/T group ($p=0.005$ - $p=0.011$ - $p=0.030$ - $p=0.004$).). There was no significant difference in the difference score between the groups. In Doppler parameters, right ovarian PI-RI was significantly lower in the L/S group at 1 month ($p=0.016$ - $p=0.039$ - $p=0.044$), but there was no significant difference at 3 months. There was no significant change in the L/T group at the 1st month, and the left ovarian S/D was higher at the 3rd month ($p=0.017$). When the two groups are compared, the change between right ovarian RI-PI in the 1st month in the L/S group is significant ($p=0.019$ - $p=0.027$), there is no significant change in the 3rd month.

Conclusions

Salpingectomy added to hysterectomy has not shown any negative effect on ovarian reserve and doppler parameters regardless of the method. Postoperative increase in FSFI scores shows that it increases regardless of the method.

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Lateral robotic trocar placement for hysterectomy in a case with morbid obesity and a large umbilical hernia

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Background

We report the technical feasibility of a modified lateral multiport trocar placement strategy utilizing the da Vinci X robotic system for hysterectomy in a patient with morbid obesity and a large right umbilical hernia. Minimally invasive abdominal access can be challenging in morbidly obese individuals, and large umbilical hernias with bowel and omental content may preclude the umbilicus as the primary site for insufflation and trocar insertion.

Methods

We present a case of a 60-year-old patient with grade 1 endometrioid endometrial carcinoma who provided informed consent for this scientific presentation. Her history included a prior caesarean section, a BMI of 62 kg/m², and a large umbilical hernia containing significant portions of the small and large bowel and greater omentum. Presenting with postmenopausal bleeding, the diagnosis was confirmed via hysteroscopy and fractional curettage six months preoperatively. Conservative management with megestrol acetate was initiated to give time to optimize her condition for surgery, considering comorbidities of major depression, uncontrolled diabetes mellitus, and a right adrenal adenoma with hyperaldosteronism. Following supine positioning with abducted legs and shoulder braces, the umbilical hernia was manually displaced laterally to the right. Initial attempts of pneumoperitoneum creation at Palmer's point, 2 cm below the left subcostal margin, were unsuccessful. A direct optical access trocar system was then used for initial camera insertion under continuous insufflation, placed approximately two handbreadths laterocaudally to the xiphoid process, followed by three 8 mm da Vinci trocars along a left lateral horizontal line with approximately 8 cm inter-trocar spacing. The initial trocar was exchanged for a standard da Vinci trocar, and the system was docked with minimal Trendelenburg positioning (~18°) due to aesthetic considerations.

Results

A stable low-pressure pneumoperitoneum of 8 mmHg was maintained. Given the patient's comorbidities, a total hysterectomy without sentinel lymph node biopsy was deemed appropriate and discussed preoperatively. An additional 5 mm working trocar was inserted cranio-medially to the primary trocar to facilitate cranial displacement of the omentum and bowel. The hysterectomy was completed uneventfully, with transvaginal specimen retrieval and vaginal cuff closure using a continuous 2-0 unidirectional barbed suture. No instrument collisions occurred. Total operative time was 151 minutes, and console time was 116 minutes.

Conclusions

Lateral placement of robotic trocars along a horizontal line offers a feasible approach for minimally invasive access in morbidly obese patients with contraindications to periumbilical entry due to

significant abdominal wall pathology. The flexibility and degrees of freedom of robotic instruments vastly improved minimally invasive operability in this case.

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validation of a scoring system to triage women with heavy menstrual bleeding into hysterectomy or uterine sparing modalities

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Background

This retrospective study was performed to validate a scoring system aiming to triage women with heavy menstrual bleeding (hmb) into hysterectomy or uterine sparing treatment. it also aimed to identify which factors in scoring system are best discriminators of the outcome and to determine whether further factors might be identified to adjust the scoring system.

Methods

All women with hmb referred to our hospital from January 2021 till December 2021 were reviewed. data including demographics, symptoms, investigations and treatment options was retrieved via our local online information system (meditech). the scoring system was applied to the collected data. outcome was measured by a two year follow up. the proposed scoring system uses 6 parameters (uterine fibroid of ≥ 3 cm, adenomyosis, uterine cavity length of >10 cm, chronic pelvic pain/ endometriosis/ dysmenorrhoea and dyspareunia, iron deficiency anaemia needing iron infusion/blood transfusion and woman's desire for hysterectomy). each parameter scores 1 apart from the uterine cavity length which scores 2. we hypothesise that a woman who scores ≥ 3 benefits from hysterectomy and who scores <3 can be successfully managed by uterine sparing modalities.

Results

A total of 361 patients were identified with 336 meeting inclusion criteria, 38 of them (11.9%) had hysterectomy. demographic and clinical variables for the patients were divided by outcome. different uterine sparing modalities were used and assessed. from the score variable a binary categorical variable was constructed as to whether they were above or below the threshold (≥ 3). Differences and association between demographic and clinical variables were examined using the welch corrected t-test, the mann-whitney and chi-squared tests.

For all 6 members of the score there was a significant association between having this factor and hysterectomy and a significant association of having a total score of ≥ 3 and hysterectomy, OR 6.23 [95%CI 4.80 – 7.67]. Each of the elements of the score system was independently associated with the outcome of hysterectomy. The scoring system has a calculated sensitivity of 0.84 [0.68-0.93], specificity of 0.99 [0.97-0.99] and positive predictive value of 0.91 [0.75-0.98]. there were no other significant differences or associations between the demographic and clinical variables measured and having hysterectomy.

a series of logistic regression models was constructed to determine which factors predict hysterectomy using initially the six factors in score and to determine their combined effect which found the strongest predictive factor was large uterine cavity ($p < .001$), followed by woman's desire for hysterectomy ($p < .001$). No other clinical or demographic factors were found to be significant predictors.

Conclusions

this scoring system as developed has high sensitivity and specificity in triaging women with hmb into hysterectomy and uterine sparing modalities with logistic regression confirming the validity of the scoring system in differentiating outcomes. Further evaluation of this system in a randomised control trial is now warranted

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Retained (and fractured) Redivac Drain Post Elective Caesarean section: A case report

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Background

Retained surgical drains are an avoidable and serious cause of postoperative morbidity. We present a case relating to a retained drain post caesarean section in a patient who subsequently underwent wound exploration for drain removal.

Methods

A 39-year-old presented for a maternal request elective caesarean section having had one prior caesarean section. Intraoperatively persistent oozing was noted after sheath closure, necessitating reopening of the sheath and for the bleeding to be reassessed. Diathermy and surgical was used for haemostasis, however given persistent oozing, a size 10 redivac drain was inserted. Day 1 post operatively the drain was removed without any difficulty documented. She was then discharged home on day 2.

She represented to her general practitioner complaining of a persistent lump at the incision site and an ultrasound had revealed an 8cm segment of drain going into the abdominal cavity.

Intraoperatively the incision site was partially opened, surrounding tissues were dissected with scissors and drain was removed with gentle traction. The rectus sheath was not opened. The redivac drain tubing was noted to be 28.5cm in length.

Results

Redivac closed suction drainage system is widely used in most UK hospitals and usually removed after 24-72 hours. In this case, there is a large discrepancy between the length of drain that was inserted and the length that was removed. There was no documentation about any difficulty with removal or the length of drain removed. Although the initial postoperative period was uneventful, the unintentional retention of a drain fragment can lead to severe consequences such as infection and chronic pain.

A review of the literature reveals relatively few complications although bowel perforation caused by closed suction drains has been described. Likewise, the consequences of applying excessive traction to a fixed intrabdominal drain may have severe consequences to the patient.

Conclusions

Surgeons should be aware of retained surgical drains as an iatrogenic cause of post-operative morbidity. Methods to prevent, identify and manage retained drains and associated complications should be within normal contemporary surgical practice.

This case highlights the need to ensure healthcare workers have explicit teaching on the different types of drains used and average length of drains so that there is no doubt the entire drain is removed. Senior input should be obtained if significant resistance is encountered during removal of drain.

Another important lesson is to ensure surgeons are careful in closure of the sheath without suturing the drain to it. Checks must be done to ensure the drain is mobile and slides through the sheath once the rectus sheath has been closed. Implementation of regular teaching sessions and awareness amongst staff of drain care will ensure this event does not recur.

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Feasibility of laparoscopic radical colpectomy in locally advanced vaginal cancer

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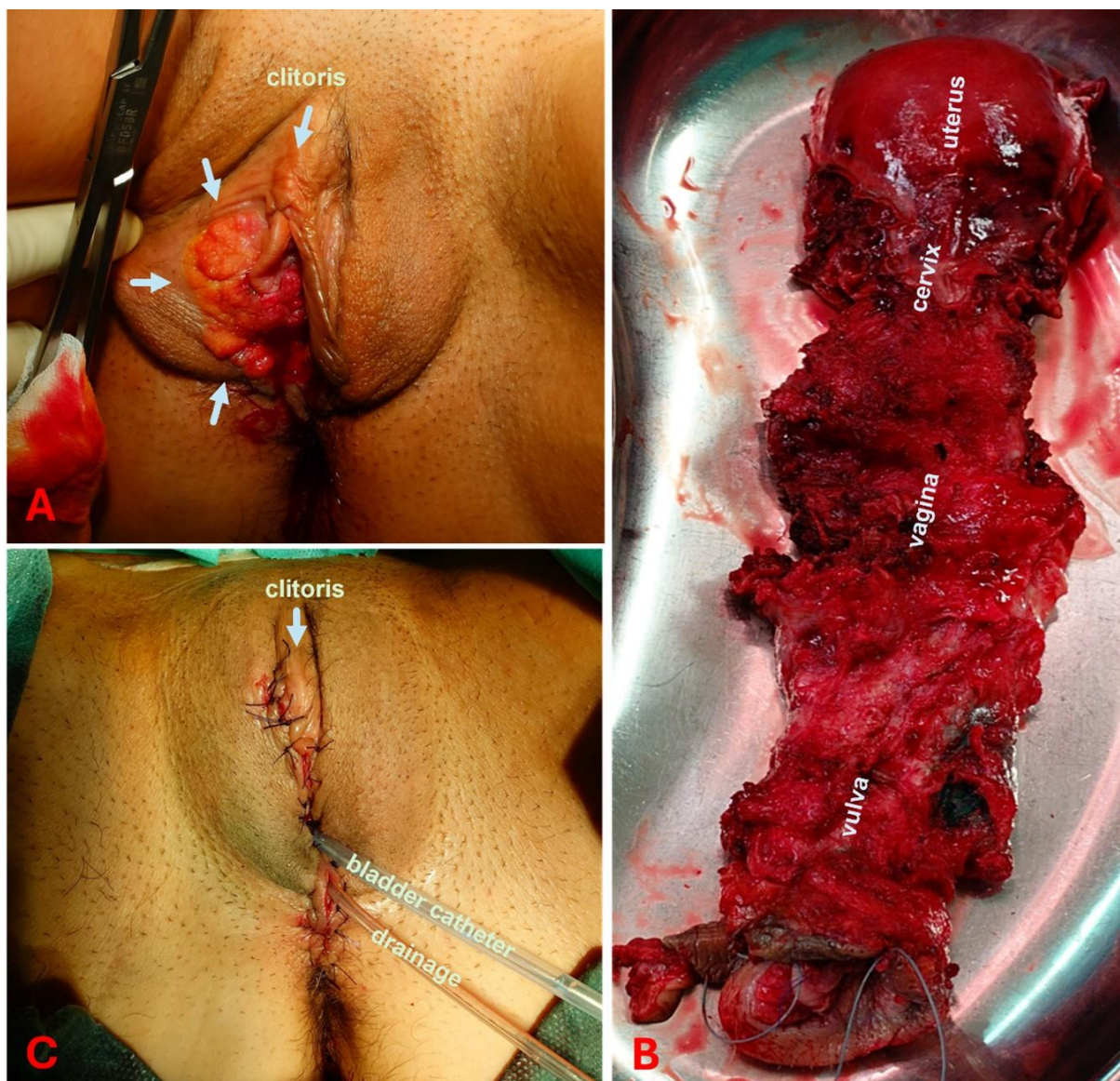
Background

This study evaluated the surgical technique, feasibility and oncological safety of laparoscopic en bloc resection for an extremely rare form of advanced vaginal cancer, presenting the clinical results.

Methods

This case report describes the treatment of a 67-year-old woman who presented with progressive pain when sitting and intermittent vaginal bleeding. She had a history of lichen planus which had been in long-term remission following treatment with topical corticosteroids. Twelve months earlier, biopsies had clearly demonstrated vulvar and vaginal intraepithelial neoplasia grade II (VIN II and VAIN II). Clinical examination revealed a tumour causing stenosis of the vaginal canal up to 3 cm proximal to the introitus. The tumour extended interlabially, involved the urethra, and had a predominant focus in the right hemivulva (Fig. 1A). Under general anaesthesia, systematic mapping biopsies were obtained. Histopathology confirmed the presence of a micro-invasive squamous cell carcinoma associated with HPV, arising in a background of high-grade intraepithelial neoplasia (VIN/VAIN III) in both the vagina and the vulva. Preoperative CT and MRI staging revealed enlarged, infiltrative, suspicious pelvic lymph nodes, but distant metastases were excluded. The primary origin of the carcinoma (vagina vs. vulva) was initially unclear.

The en bloc surgical treatment comprised the following: laparoscopic radical hysterectomy with bilateral salpingo-oophorectomy and colpectomy down to the pelvic floor; vulvectomy with preservation of the clitoris; resection of the distal third of the urethra with transvaginal removal of the en bloc specimen (see Figure 1B); bilateral radical pelvic lymphadenectomy; and bilateral inguinal sentinel lymph node dissection. The patient expressed a preference against undergoing vaginal reconstruction surgery. The vaginal orifice was closed using transvaginal levator sutures, laparoscopic sutures, and the stumps of the sacrouterine ligament and rotundum on both sides, along with the peritoneum (see Figure 1C).



Results

The surgical procedure was performed for a duration of 600 minutes, with an estimated blood loss of 300 millilitres. The intraoperative and postoperative course was uneventful. The patient exhibited a satisfactory general condition and was discharged from hospital on the 11th postoperative day. Histopathological analysis confirmed complete resection of the tumour with sharp margins (pT3, pN0, LO, VO, Pn0, R0). Subsequent follow-up examinations revealed primary wound healing with optimal functional and aesthetic outcomes. At the most recent examination, eight months after the procedure, the patient reported no bladder or bowel dysfunction and no neurological deficits or limitations in activities of daily living. There was no evidence of a recurrence.

Conclusions

The present study demonstrates the efficacy of laparoscopic techniques in the management of advanced vulvar cancer, with a low incidence of complications and no compromise to oncological safety, while maintaining pelvic floor function.

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Role of operative hysteroscopy in the management of Enhanced myometrial vascularity secondary to retained pregnancy tissue

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Background

A true uterine arteriovenous malformation (AVM) represents a shunt between branches of the uterine artery (UA) and the myometrial venous plexus.

In contrast, Enhanced myometrial vascularity (EMV) beneath retained pregnancy tissue is therefore part of a normal physiological process and its disappearance would be anticipated once the retained tissue has been removed.

These two different entities, leading to confusion as their clinical symptoms, and ultrasound diagnosis are very similar. This has led to the emergence of the role of operative hysteroscopy in the management of EMV with Retained products of conception (RPOC).

The Objective: was to demonstrate the role of operative hysteroscopy in the management of EMV associated to RPOC that can be preceded by a vascular procedure as a laparoscopic hypogastric artery ligation (LHAL), according to an haemorrhagic risk stratification based on the measurement of peak systolic velocity (PSV), hemodynamic status, and anaemia (<8 g/dL).

Methods

This is a retrospective, longitudinal, and continuous study conducted in our department over a period of three years, from January 1, 2022, to October 20, 2024. During this period, we collected 13 cases of EVM with RPOC .

Results

The mean age of the patients was 34 years. The main risk factors of EVM associated to RPOC identified in our series were a history of caesarean section and endometrial curettage. Clinically, 12 patients presented with persistent metrorrhagia in a post-abortion context. Only one patient was asymptomatic.

The delay between symptom onset and the post-abortion period ranged from a minimum of 2 weeks to a maximum of 3 months.

The diagnosis of EVM secondary to trophoblastic retention was based on doppler ultrasound findings: an heterogeneous hyper vascular mass primarily involving the endometrium and sometimes the myometrium, characterized by a peak systolic velocity (PSV) ≥ 20 cm/s.

In our study, the PSV ranged from 12 to 80 cm/s.

All patients underwent conservative surgical treatment, which was associated or not with bilateral LHAL according to a haemorrhagic risk stratification.

Two patients had anaemia with haemoglobin levels below 8 g/dL, requiring a transfusion.

Six patients with a PSV greater than 40 cm/s underwent a vascular procedure combined with hysteroscopic resection. Four patients with a PSV between 20 and 40 cm/s underwent operative hysteroscopy alone. Those with a PSV less than 20 cm/s were candidates for ultrasound-guided endometrial aspiration.

No complications were detected during or after the operation. The resolution of the EMV was verified by ultrasound one month after the procedure for all patients.

Conclusions

Understanding the pathophysiology of EMV secondary to RPOC and its distinction from the entity known as "uterine arteriovenous malformation" has allowed for a new therapeutic approach based on operative hysteroscopy, associated or not with a vascular procedure, according to a haemorrhagic risk stratification that combines the measurement of PSV, the patient's hemodynamic status, and anaemia.

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The Impact of Robotic Gynaecological Surgery in a Small Community Hospital: Our Experience

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Background

This study aims to demonstrate how the introduction of the Da Vinci XI System in a small community hospital has enhanced the gynaecological surgery program. Recent evidence suggests that robotic assistance in gynaecology reduces operative time, complication rates, and conversions to open surgery.

Methods

We retrospectively analysed gynaecological surgical activity at our hospital over the past two years (2023–2025) following the introduction of the Da Vinci XI robotic system. Our gynaecology unit operates with four recovery beds and one dedicated surgical theatre available twice per week (7 a.m. to 6 p.m.), with approximately 400 procedures annually across all surgical disciplines. Robotic surgery was introduced for the following procedures: benign hysterectomy, sacrocolpopexy, malignant hysterectomy with lymphadenectomy, and surgery for deep endometriosis. Initially, one robotic-trained surgeon and two experienced laparoscopic surgeons conducted the procedures. By the end of 2023, all surgeons involved had completed robotic surgery training.

Results

A total of 280 robotic gynaecological procedures were performed: - 70 oncologic cases: 20 cervical cancers, 50 endometrial cancers- 210 benign cases: 20 deep endometriosis, 115 uterine myomas, 75 uterine prolapses. Surgical approaches included: - Radical hysterectomy with lymphadenectomy for all malignancies (based on clinical staging)- Rectal shaving and excision of the vaginal lesion in all deep endometriosis cases- Total hysterectomy for all myoma cases- Subtotal hysterectomy with sacrocolpopexy using the Burch technique for prolapse, adapted to the grade/type. To reduce costs, three robotic arms were used in a large proportion of cases. All patients were discharged on postoperative day 2. Average surgical times were:- 54 minutes for benign hysterectomy- 86 minutes for oncologic hysterectomy with lymphadenectomy- 100 minutes for sacrocolpopexy- 80 minutes for deep endometriosis surgery

Conclusions

The introduction of the Da Vinci XI robotic system in our small community hospital has enabled the safe, efficient, and precise performance of complex gynaecological surgeries. We significantly expanded the range and number of procedures, including advanced surgeries such as sacrocolpopexy and deep endometriosis treatment. The robotic platform offers enhanced access to anatomically challenging regions, even for highly skilled laparoscopic surgeons. The strategic use of three robotic arms also contributed to cost containment, supporting the feasibility of robotic surgery in resource-limited settings.

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Case Report: Uterine Arteriovenöse Malformation

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Background

Uterine arteriovenous malformation (AVM) is a rare, potentially life-threatening disease. In contrast to otherwise localized, mostly congenital AVMs, uterine AVMs are often acquired - typically after uterine interventions such as curettage, caesarean section or pregnancy-related events. Bleeding disorders are the main symptom.

Methods

We present the case of a 41-year-old female patient who developed secondary amenorrhea after a vacuum curettage. Based on the clinical history and the findings of the transvaginal sonography (TVS), there was an urgent suspicion of a uterine AVM. Magnetic resonance imaging (MRI) with contrast medium application confirmed the diagnosis. Embolization of the left uterine artery was performed without complications. Follow-up examinations showed a complete regression of the AVM.

Results

With the increasing frequency of uterine surgery, the incidence of uterine AVMs will also increase. The clinical implications are significant when it comes to fertility preservation and ongoing family planning. For the first time, a uterine AVM in the presence of amenorrhea is described here and a diagnostic and therapeutic algorithm for uterine AVM is offered.

Conclusions

Given the high risk of life-threatening bleeding that can be associated with an AVM, this differential diagnosis should be carefully considered and ruled out in cases of bleeding disorders following pregnancy or uterine surgery. An accurate diagnosis prior to surgical interventions, such as curettage, is crucial to avoid serious complications and ensure appropriate treatment.

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Benign metastatic leiomyomatosis with lymphogenous and pulmonary manifestations

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Background

Extrauterine leiomyomatosis is a rare, clinically relevant entity in which benign, smooth leiomyoma-like muscle cells proliferate outside the uterus. The etiology remains unclear. It usually affects premenopausal women with uterine fibroids with or without previous surgical removal of the fibroids. Three forms must be differentiated: intravenous leiomyomatosis, benign metastatic leiomyomatosis and disseminated peritoneal leiomyomatosis. The diagnosis can only be made on the basis of histopathology and immunohistochemistry. Clinically, the disease often manifests itself asymptotically and is usually discovered by chance during imaging procedures.

Methods

We report on a 42-year-old female patient who presented for tumour detection due to sonographically impressive retroperitoneal lymphadenopathy and unspecific symptoms. In the presence of autoimmune hepatitis under azathioprine therapy, abdominal ultrasonography was performed as part of the follow-up. A laparoscopy with myoma enucleation and morcellation had been performed in 2008 for a progressive, symptomatic uterus myomatosis. The gynaecological examination revealed a uterus myomatosis as well as a smooth, echogenic, solid mass measuring 31 x 27 x 34 mm in the right adnexal lobe. A CT thoracic abdomen confirmed metastatic aspects, para-aortocaval lymph nodes, pulmonary lesions and a solid mass in the pelvis. Tumour markers and other surrounding diagnostics were unremarkable.

Results

Exploratory laparoscopy was performed. Intraoperatively, a 3 cm large, myoma-typical finding in the Douglas was confirmed, as well as para-aortocaval enlarged, myomatous interspersed lymph nodes. Histopathologic evaluation confirmed a leiomyoma and lymph nodes with smooth muscle formations, corresponding to benign metastatic leiomyomatosis, without histomorphologic and immunohistochemical malignancy criteria. The postoperative course was unremarkable. Due to the presence of autoimmune hepatitis, close follow-up was initially preferred to primary hormone therapy.

Conclusions

Benign metastatic leiomyomatosis is a rare differential diagnosis in women with previously known leiomyomas and unclear lymphogenous, hematogenous or peritoneal metastasis. There is no standardized treatment recommendation. In addition to surgical resection, hormone-modulating approaches are the mainstay of therapy, particularly in cases where estrogen and progesterone receptor positivity has been proven. Despite the benign histomorphology, benign metastatic leiomyomatosis exhibits metastatic behaviour, the pathogenesis of which has not yet been clearly clarified. Malignant degeneration cannot be ruled out, which makes long-term close follow-up of these patients essential.

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Robotic-assisted repair of vesicovaginal fistula: A modern approach

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Background

Vesicovaginal fistula (VVF) is a rare but significant complication of hysterectomy, with an incidence of approximately 0.1%. It primarily arises from infection, ischemia, or iatrogenic injury to the bladder. Risk factors include dense bladder adhesions, prior pelvic surgeries, and conditions such as endometriosis, which complicate surgical dissection. Patients typically present postoperatively with continuous urinary leakage, profoundly affecting their quality of life. Robotic-assisted surgery has potential to transform VVF management.

We aim to describe the stepwise robotic-assisted surgical approach to VVF repair and emphasise the advantages of robotic-assisted techniques in improving surgical outcomes and patient recovery.

Methods

Diagnosis of VVF

VVF diagnosis is best confirmed using imaging modalities such as contrast-enhanced CT or retrograde cystogram, which accurately delineate the fistulous tract.

Stepwise Robotic Technique

A guide wire, Foley, or ureteral catheter is used to aid in identifying the fistulous tract.

Precise robotic-assisted dissection of the bladder and vaginal tissues is performed to isolate the fistula. Unlike traditional approaches, robotic techniques eliminate the need to bivalve the bladder, limiting the size of the openings in the bladder and vagina and reducing postoperative complications.

Robotic dexterity facilitates a water-tight, multi-layer closure of the fistulous openings. The closure is achieved without time-consuming steps like interposing vascularised tissue flaps (e.g. omental or Martius flaps). Suturing the bladder and vaginal defects in perpendicular directions reduces the risk of recurrence.

Drains are avoided. Catheters are typically removed 7-10 days postoperatively without requiring cystograms.

Results

Robotic-assisted surgery can transform VVF management by providing enhanced dexterity, superior visualisation, and minimally invasive techniques. These advancements lead to reduced blood loss, shorter hospital stays, minimal postoperative pain, and faster recovery.

Conclusions

Current evidence demonstrates high success rates for fistula closure and low complication rates, even in complex or recurrent cases. This stepwise robotic approach underscores the safety, efficacy, and transformative impact of robotic surgery in VVF management.

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Robotic surgery for large fibroid uteri: A step-by-step guide to optimising outcomes

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Background

With the continuous advancement of minimally invasive techniques, most hysterectomies are now performed laparoscopically or robotically. However, myomectomy and hysterectomy for large fibroid uteri remain among the most frequent indications for laparotomy in gynaecology due to their technical complexity. The advent of robotic- assisted surgery has revolutionised the management of large fibroids, providing enhanced visualisation, precision, and ergonomics, enabling surgeons to perform these procedures safely and effectively via a minimally invasive approach.

Methods

We present a detailed, step-by-step robotic approach to myomectomy and hysterectomy for large fibroid uteri with emphasis on surgical techniques to minimise complications, maximise efficiency, and achieve excellent clinical outcomes.

Results

We demonstrate use of preoperative fibroid mapping using ultrasound and MRI for surgical planning, allowing for precise identification of fibroid size, number, and location. We demonstrate complete ureterolysis as a tool to aid protection of critical structures in distorted pelvic anatomy. These along with use of vasopressin significantly reduces intra-operative blood loss, while cavity delineation with indocyanine green (ICG) fluorescence enhances visualisation of tissue planes and vascularity, improving precision and safety.

Conclusions

Robotic myomectomy and hysterectomy for large fibroids are associated with low rates of blood loss, rare intra-operative complications, and shorter recovery times, despite a modest increase in operative duration compared to traditional laparotomy. Importantly, robotic techniques allow for meticulous suturing and restoration of uterine integrity in myomectomy which is crucial for patients desiring future fertility.

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Hysterectomy in cases with severe endometriosis and fibroids: enhancing safety with robotic-assisted ureterolysis

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Background

Performing a hysterectomy in women with severe endometriosis and multiple fibroids poses significant challenges due to the potential for injury to critical structures such as the ureters, bladder, and bowel. Dense adhesions, distorted anatomy, and the infiltrative nature of endometriosis increase the complexity of the procedure, necessitating advanced surgical techniques to minimise complications and optimise patient outcomes.

Meticulous ureterolysis remains a cornerstone of safe surgical practice in these cases, allowing for clear identification, lateralisation, and protection of the ureters. Additionally, medialisation of the bowel facilitates access to deep pelvic structures and enhances visualisation. These steps are technically demanding, particularly in cases involving obliterated pelvic anatomy or concurrent pathologies such as large fibroids.

Our objective is to provide a systematic step-by-step demonstration of performing ureterolysis in cases of severe endometriosis and multiple fibroids, highlighting its critical role as a key step in complex hysterectomies.

Methods

We present a series of surgical videos demonstrating ureterolysis in cases with severe endometriosis and multiple fibroids.

Results

We can demonstrate that robotic-assisted ureterolysis helps carefully dissect and mobilise the ureters from dense adhesions and fibrotic tissue, creating a safer surgical field and minimising the risk of iatrogenic injury. This in turn leads to fewer complications, less blood loss, reduced length of stay and better outcomes for patients.

Conclusions

Robotic-assisted surgery has emerged as a valuable tool for addressing the surgical challenges in benign complex gynaecological surgery. Enhanced three-dimensional visualisation, wristed instrumentation, and improved precision enable surgeons to navigate challenging anatomical landscapes with greater accuracy.

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The Outcomes of Laparoscopic Surgery for Tuboovarian Abscess Performed within the First 48 Hours of Hospitalization

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Background

In a case of tubo-ovarian abscess (TOA) for which surgical treatment is planned, surgery is usually performed after at least 48 hours of parenteral antibiotics. Our aim is to investigate the impact of timing of surgery after hospitalization on outcomes in cases operated on laparoscopically for TOA or pyosalpinx.

Methods

In this cross-sectional cohort study 93 TOA/pyosalpinx patients, confirmed the diagnose via laparoscopy, were included in the study. All patients were started on parenteral antibiotic treatment within the first 2 hours of hospitalization. The patients were divided into 2 groups as those who underwent surgery within the first 48 hours of hospitalization (n=42, 45.2%) and after 48 hours (n=51, 54.8%). Age, parity, abscess size, vital signs, hemogram and CRP values, duration of surgery, parenteral antibiotic use and hospital stay, complication development rates, and need for rehospitalization were compared between the groups.

The descriptive results were indicated as numbers and percentages in categorical data, and as mean±SD (min-max) or median (IQR) (min-max) values in continuous data according to their compliance with normal distribution. In comparisons of continuous data between groups, Independent Sample T test was used for normally distributed data, and Mann Whitney test for not normally distributed. Categorical data were analysed using the chi-square test. $p<0.05$ was considered statistically significant.

Results

The age, parity, initial vital signs, and laboratory values at hospital admission were similar in the two groups ($p\geq 0.05$). The earliest time to surgery was 6 hours after admission. The duration of surgery (107 (61) vs. 125 (65); $p=0.177$) and the conversion rate from laparoscopy to laparotomy were similar between groups (14.3% (6/42) vs. 9.8% (5/51); $p=0.505$).

Complication rates were similar (19.0% vs. 21.6%; $p=0.764$). Intraoperative and postoperative complication rates (7.1% vs. 5.9%, $p=0.805$ and 14.3% vs. 15.7%, $p=0.851$, respectively) and trocar entry site wound infection rates were also similar between groups (9.5% vs. 9.8%, $p=0.964$). The rehospitalization rate one month after hospital discharge was not different between the two groups (14.3% vs. 9.8%, $p=0.505$). In two cases that were operated on after 48 hours, re-hospitalization occurred at follow-up after discharging due to the formation of an intraperitoneal abscess.

The total duration of parenteral antibiotic use in hospital (7 (2) (min: 3 – max: 12) vs 10 (3) (min: 5 – max: 33), $p<0.001$) and total hospital stay (7 (2) (min: 3 – max: 13) vs 10 (4) (min: 5 – max: 33)) were significantly longer in those operated on after the first 48 hours ($p<0.001$).

Conclusions

In TOA/pyosalpinx, laparoscopic surgery performed within the first 48 hours of hospitalization and initiation of parenteral antibiotics without waiting for 48-hour antibiotic suppression, as is traditionally done, allows for shorter antibiotic use and hospital stay without altering operative times and complication rates.

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Perioperative management of infected ovarian endometrioma: Outcomes of transvaginal ultrasound-guided puncture drainage and laparoscopic surgery

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Background

Infected ovarian endometrioma is generally preceded by antibiotics therapy, however, surgical treatment is necessary if the infection is resistant to antibiotics. The transvaginal puncture drainage has been reported to be effective as a conservative treatment in the acute phase. In this study, we describe a retrospective review of the outcomes of cases in which transvaginal puncture drainage and laparoscopic surgery were performed at our hospital for infected ovarian endometrioma.

Methods

This retrospective study included 17 cases with infected ovarian endometrioma who underwent transvaginal puncture drainage and laparoscopic surgery between January 2020 and December 2024. The perioperative course and outcome of 17 cases were reviewed.

Results

All 17 cases received antibiotics therapy initially, and 13 cases underwent concomitant transvaginal puncture drainage. In 12 of 13 transvaginal drainage cases (92%), the infection resolved, and emergency surgery was avoided. Laparoscopic surgery was performed in 10 cases, eight cases underwent elective surgery after infection remission, two cases underwent emergency surgery due to resistant to conservative treatment. Laparoscopic ovarian cystectomy was performed in five cases, adnexectomy in four cases, and hysterectomy and adnexectomy in one case, according to fertility intent and age. The median operative time was 136 minutes (range 94-232 minutes) and intraoperative blood loss was 33 ml (10-1300 ml). There were no intraoperative injuries or conversion to open surgery, however, one of the two cases who underwent emergency laparoscopic surgery had intraoperative blood loss of 1300 ml due to severe adhesions and a tendency to bleed, requiring an allogeneic blood transfusion. In addition, postoperative hematoma formed in the Douglas' pouch and the infection flared up, requiring re-hospitalization for antibiotics therapy. No recurrence of infection was observed in the other 16 cases.

Conclusions

Transvaginal puncture drainage is minimally invasive, highly effective, and useful as a bridge to safe surgical procedures. In cases that resist conservative treatment and require emergency surgery, the degree of surgical difficulty is particularly high due to severe adhesions and tendency to bleed, requiring skilled surgical techniques.

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**Comparing Two Types of Robotic single-site Myomectomy using Propensity Score Matching:
Coaxial with da Vinci Xi vs. da Vinci SP system**

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Background

This study aimed to compare surgical outcomes between Coaxial Robotic Single-Site Myomectomy (RSSM) with da Vinci Xi system and da Vinci SP system.

Methods

Between October 2020 and January 2024, a retrospective review was conducted on 81 women who underwent coaxial-RSSM and 108 women who underwent myomectomy using the da Vinci SP system. Following propensity score matching (PSM) based on the total number of myomas, largest myoma size, and myoma type according to FIGO classification, we evaluated and compared patient characteristics and surgical outcomes.

Results

Coaxial-RSSM group showed significantly less blood loss (102.33 ± 61.01 vs. 203.98 ± 163.15 mL, $p < 0.001$) and shorter operative time (91.22 ± 18.25 vs. 148.69 ± 45.62 minutes, $p < 0.001$) compared to da Vinci SP surgery. Haemoglobin decrement was also significantly lower in the Coaxial-RSSM group compared to SP group (1.69 ± 0.93 vs. 2.85 ± 1.30 , $p < 0.001$). Hospital stay was shorter in the SP group compared to the coaxial group (4.07 ± 0.76 vs. 2.06 ± 0.24 minutes, $p < 0.001$). However, postoperative complications such as ileus, fever, and wound dehiscence did not show statistically significant differences between the two groups. When additional comparisons were made with cases performed by four different surgeons, the results were consistent with the 1:1 surgeon outcome.

Conclusions

Coaxial-RSSM was associated with shorter operative time and lower estimated blood loss. A follow-up prospective study is warranted for a more comprehensive comparison of surgical outcomes between the two techniques.

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Training residents in hysteroscopy: from operating room to office. A one-chance procedure.

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Background

The transition of hysteroscopy from the operating room under general anaesthesia to the outpatient setting without anaesthesia has profoundly impacted residency training in obstetrics and gynaecology. Previously, residents learned hysteroscopic skills in a controlled environment, free from patient discomfort and time pressure. In contrast, the current reality demands that trainees perform and learn hysteroscopy in an office setting, where the awake patient's comfort and cooperation are crucial. This shift presents educational and clinical challenges, especially considering that office hysteroscopy is effectively a "one-chance" procedure: if pain, vasovagal response, or bleeding occur, the attempt is usually aborted and cannot be repeated in the same session.

Methods

A focused educational review was conducted on the implications of teaching hysteroscopy in the outpatient setting without anaesthesia. We analysed the shift in training models, the learning curve in current practice, and critical incidents that lead to early procedure termination. Emphasis was placed on comparing past and current approaches to hysteroscopic skill acquisition and identifying strategies to support safe, effective training in today's environment.

Results

In the previous training model, residents developed endoscopic dexterity—including handling angled optics, uterine navigation, and instrumentation—on anesthetized patients in the OR. This allowed for gradual skill development without concern for patient discomfort. In contrast, current residents must now master technical skills while simultaneously managing awake patient interaction, pain prevention, and emotional support. The lack of margin for error in this setting, combined with the single-attempt nature of the procedure, increases the risk of negative outcomes. Structured simulation-based training, careful patient selection, and close supervision during initial cases are essential to preserve patient safety and ensure resident competence.

Conclusions

The shift from operative hysteroscopy under anaesthesia to outpatient procedures without anaesthesia demands a rethinking of how residents are trained. Educators must acknowledge the "one-chance" nature of the outpatient hysteroscopy and provide residents with early, protected learning opportunities, including simulation, supervised exposure, and training in communication and emotional responsiveness. Recognizing and adapting to this change is vital to protect the patient experience, ensure procedural success, and uphold educational quality in gynaecology training programs.

We propose a standardized training model in office hysteroscopy for obstetrics and gynaecology residents, divided into four stages of increasing complexity.

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Hematosalpinx? Tubal ectopic? - A congenital absence of unilateral Fallopian tube and Ovary

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Background

A 32-year-old female presented to the emergency department with left sided pelvic pain and a positive pregnancy test.

She had an ultrasound scan which showed an anembryonic intrauterine pregnancy and left tube haematoma. Patient was booked for an urgent MRI to further evaluate the left Tube before surgical management of miscarriage. She was hemodynamically stable, and her haemoglobin was 130g/l.

Methods

This is a case report on a finding of unilateral absence of a fallopian tube and an ovary.

Results

The Beta HCG on admission was 127670 IU/l. As the patient was clinically stable, she was followed up in the early pregnancy unit. The initial ultrasound (US) scan showed an anechoic area (MSD= 31.5mm) within the endometrial cavity and low-level echoes within. However, there was no yolk sac or foetal pole identified, and it was concluded as an anembryonic pregnancy.

Within the left adnexa there was a tubular structure which demonstrated low level echoes within, appearances were suggestive of a haematosalpinx and therefore an ectopic pregnancy can also not be excluded. In view of a high beta HCG and the findings on the US, a MRI pelvis was requested. The MRI pelvis showed an irregular sac within the cavity. The right ovary is seen normal with evidence of corpus luteal cyst. The left ovary could not be identified and a tubal structure in left adnexa was noted with intermediate signal on T2w and high signal on T1w - raising possibility of hematosalpinx. There was no viable pregnancy in left adnexa. The serial beta HCG was showing a slow decrease in trend and was at 90152 IU/l, 16 days after initial presentation. The findings were discussed with the patient, and she was listed for a laparoscopy with removal of a fallopian tube and evacuation of uterus.

At laparoscopy, on the posterior aspect of the uterus a venous dilatation noted? AV malformation? venous sinus? origin. Ureters and iliac vessels on both sides visualised. Iliac vessels tracked up to common iliac vessels and there was no evidence of fallopian tube or ovary on the left side. Surgical evacuation of uterus was completed at the same time and products of conception was confirmed on histology.

Conclusions

Isolated anomalies of the fallopian tubes, the end result of abnormal development of the proximal unfused portions of the paramesonephric ducts, are rare. As this is a rare finding and can have significant implications careful counselling and multidisciplinary team involvement is crucial when consenting for laparoscopy.

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Learning curve analysis of vNOTES for benign adnexal pathologies: a CUSUM analysis of the first 100 cases in The Netherlands.

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Background

Vaginal natural orifice transluminal endoscopic surgery (vNOTES) is an alternative to conventional approaches for benign adnexal surgery, offering benefits such as faster recovery and improved cosmetic outcomes. However, the technique presents unique challenges due to limited workspace and altered surgical orientation, requiring specific skills and experience. While prior studies suggest a variable learning curve, data remain limited. This study aims to assess the learning curve of vNOTES for benign adnexal surgery performed by two gynaecologists, using Cumulative Sum (CUSUM) analysis on the first 100 procedures at Zuyderland Medical Centre.

Methods

A retrospective cohort analysis was performed on the first 100 vNOTES adnexal procedures conducted between March 2020 and October 2024 by two gynaecologists who had already completed the learning curve for vNOTES hysterectomy. Baseline characteristics and data of intra- and postoperative surgical outcomes were collected. Learning curves were constructed using CUSUM analysis based on operative time and perioperative complications as the primary performance indicators, with results stratified by surgeon. A predefined reference time was established based on the mean operative time of the final 20 cases. Learning curve inflection points were identified to determine the number of procedures required to achieve technical proficiency.

Results

Results will be analysed and presented on ESGE 2025.

Conclusions

Results will be analysed and presented on ESGE 2025.

Serum Anti-Müllerian Hormone Levels and Endometriosis Surgery: Unravelling the Evidence

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Background

Assessment of ovarian reserve is essential in women seeking fertility, and serum Anti-Müllerian Hormone (AMH) levels are a reliable marker. Endometriosis—a benign condition with three main phenotypes: superficial peritoneal endometriosis (SUP), ovarian endometrioma (OMA), and deep endometriosis (DE)—is associated with infertility. However, the specific impact of endometriosis itself and its surgical management on AMH levels remains uncertain. This narrative review aims to evaluate the effect of different endometriosis phenotypes and related surgeries on AMH levels and to explore the predictive value of pre- and post-operative AMH levels for reproductive outcomes in women attempting to conceive.

Methods

This is a narrative review of the literature assessing changes in AMH levels associated with endometriosis phenotypes and various surgical interventions, including excisional and non-excisional techniques. Studies examining the relationship between AMH and fertility outcomes pre- and post-surgery were analysed.

Results

OMA is consistently linked to reduced AMH levels and an accelerated decline over time. OMA cystectomy further decreases AMH levels, though partial recovery may occur post-operatively. Non-excisional surgeries for OMA better preserve ovarian tissue but still cause a temporary AMH decline, albeit less severe than with cystectomy. Non-thermal haemostasis methods appear to minimize AMH loss during cystectomy. Pre-operative AMH levels are positively correlated with the likelihood of post-operative spontaneous conception but not live birth rates. They also predict the risk of diminished ovarian reserve (DOR). Post-operative AMH levels and the magnitude of decline within one year after OMA cystectomy also correlate with fertility outcomes. SUP has little to no effect on AMH levels. DE is associated with lower AMH values, and surgical treatment of DE may further reduce AMH.

Conclusions

While endometriosis—particularly OMA and DE—negatively impacts AMH levels, these changes do not necessarily reflect a decline in reproductive potential. AMH levels before and after surgery provide valuable prognostic information regarding fertility outcomes. Future research should investigate the impact of endometriosis in extra-ovarian sites on ovarian reserve.

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The comparison between robotic assisted pectopexy versus transvaginal mesh in treating advanced pelvic organ prolapse

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Background

After the warning letters for transvaginal mesh (TVM) from U.S. Food and Drug Administration (FDA), pelvic reconstructive surgery has been shifted trans-vaginally route to trans-abdominal route, thereafter. Laparoscopic sacro-colpopexy (SCP) is an abdominal approach for pelvic organ prolapse (POP). However, it needed more meticulous and challenging suture techniques. Laparoscopic pectopexy, by Banerjee and Noé in 2011, has been proposed as a safer alternative. With the advances of robotic surgery, herein, we presented the comparison between robotic-assisted mesh-augmented pectopexy (RAPP) with *da Vinci Surgical System* (Intuitive Surgical, Inc) versus transvaginal mesh (TVM) in treating advanced POP.

Methods

Between Dec, 2022 and Feb, 2025, patients with stage III uterine prolapse, with/without cystocele, rectocele, or urodynamic stress incontinence (USI), who received RPP, were recruited as study group. During the same recruitment period, patients who received TVM either Calistar S (Promedon) or Minimally Invasive Prolapse Solution, MIPS (Neomedic) were recruited into comparison group, with 1: 2 ratio. The following parameters were used as outcome measurement, e.g. anatomic correction with POP-Q (point Ba, C, Bp, and total vaginal length, TVL), urodynamic study, operation time, blood loss, length of hospitalization (LOH), peri-operative complication, e.g. bladder injury, rectal injury, mesh erosion, and urodynamic parameters.

Results

During the recruitment period, a total of 29 RPP cases (mean age 62.1 years (± 5.1 years standard deviation), were recruited as study group; and 58 cases (64.5 years ± 8.3 years) with TVM as control group, respectively. RPP group had better anatomic correction (better C point, and TVH), less blood loss, shorter LOH, similar bladder injury (1/ 29 vs 2/ 58), fewer vaginal mesh erosion (0/ 29 vs 4/ 58); similar urodynamic parameters, e.g. bladder outlet obstruction relief, and de novo urodynamic stress incontinence; but longer operation time (console time) and preparatory time, as compared with TVM group.

Conclusions

In the post-TVM warning era, RAPP may play a more important role in pelvic reconstructive surgery. Our study reported more successful anatomical and objective outcome in pectopexy, as compared with TVM. RAPP alleviated meticulous suture techniques, significant mesh erosion risks, but longer operation time, and higher cost. Robotic surgery may offer a promising alternative, in addition to TVM, for advanced POP.

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Rare Case Report: ureteral mass that must be distinguished from adnexal mass

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Background

Anormal uterin kanama ve kitleler ile malignite arasındaki ilişki yakından değerlendirilmesi gereken patolojilerdir. Over kitlesi nedeniyle takip edilen ve nadir görülen üreteral kitle tanısı konulan bir hastayı sunmayı amaçladık.

Methods

The patient, who applied to Selçuk University Faculty of Medicine, Department of Obstetrics and Gynaecology, complaining of abdominal pain and abnormal uterine bleeding, was examined for further examination. The patient who applied to Selçuk University Faculty of Medicine, Department of Obstetrics and Gynaecology, with complaints of abdominal pain and abnormal uterine bleeding, was examined for further examination. The patient who had left nephrectomy was thought to have hydrosalpinx and heterogeneous ovarian cysts in the left and right adnexal area in the USG imaging, and it was evaluated as a mass in the ureteral region in the MRI examination. The patient, whose endometrial biopsy and tumour markers were regular, was transferred to urology. Diagnostic laparotomy was planned, especially after nephrectomy, to evaluate benign or malignant masses such as ureterocele.

Results

The coexistence of ureteral and ovarian masses is quite rare, and this association may create severe difficulties in diagnosing and treating the cases. Ureteral masses are mostly of urothelial carcinoma origin and typically present with symptoms such as haematuria, flank pain, and hydronephrosis. Ovarian masses are usually asymptomatic and can be detected incidentally during gynaecological examinations or imaging; however, malignant ones, especially epithelial ovarian cancers, may present with lower abdominal pain, distension, and gastrointestinal symptoms. The literature emphasizes that in cases where these two types of masses are present simultaneously, the possibilities of metastatic disease, direct invasion, or two separate primary tumours should be considered. Especially in advanced stages of ovarian cancer, ureteral obstruction or invasion due to retroperitoneal spread may be frequently observed. Similarly, if ureteral tumours expand in the pelvis, they may cause secondary effects by establishing adjacency to ovarian structures. Therefore, in such cases, the localization of the lesions, depth of invasion, and spreading routes should be evaluated in detail with advanced imaging methods such as magnetic resonance imaging (MRI) and computed tomography (CT). In addition, in cases where both masses risk malignancy, surgical exploration and frozen-section biopsies play a critical role in confirming the diagnosis.

Conclusions

Mastering female anatomy and knowing the neighbourhoods is a warning for possible other organ pathologies. A multidisciplinary approach is essential.

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Diagnostic performance and service evaluation of a one-stop postmenopausal bleeding clinic: a single-centre retrospective cohort study

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Background

One-stop clinics for postmenopausal bleeding (PMB) aim to enhance the diagnostic pathway by combining transvaginal ultrasound (TVUS), outpatient hysteroscopy, and endometrial biopsy into a single visit. This approach seeks to reduce delays, improve patient experience, and increase diagnostic accuracy in women referred under the two-week wait (2WW) protocol. This study evaluates the diagnostic performance, procedural outcomes, and service delivery of a newly established one-stop PMB clinic at the University Hospital of North Tees, NHS Foundation Trust.

Methods

We retrospectively reviewed 200 women referred under the 2WW pathway between July 2024 and January 2025. Women with prior hysterectomy or incomplete documentation were excluded. A total of 181 cases met the inclusion criteria. Data collected included age, BMI, endometrial thickness (ET), procedural details, histopathology outcomes, general anaesthesia (GA) use, time intervals from referral to clinic, diagnosis, and treatment. Based on history, examination, and ultrasound findings, patients with ET <4 mm and low clinical suspicion were discharged with formal safety-netting advice to reconsult primary care if symptoms recurred. Experienced consultants performed all procedures. This was a descriptive, retrospective cohort evaluation.

Results

The median age was 58.5 years, and the median BMI was 30.

- Endometrial adenocarcinoma was diagnosed in 11/181 (6.1%) cases, and 2/181 (1.1%) were pre-cancerous lesions.
- Benign pathology was found in 112/181 (61.9%) women.
- 60/181 (33.2%) were discharged without biopsy due to ET <4 mm and low clinical suspicion; all received safety-netting advice and referral to primary care.
- Mean ET was 10.95 mm in cancer cases and 6 mm in benign cases.
- Pipelle sampling was attempted in 120/181 cases (66.3%), and hysteroscopy was performed in 111/181 (61.3%).
- GA was required in 12/111 (10.8%) hysteroscopies, primarily due to patient discomfort. No major procedural complications were reported.
- 92.4% of patients were seen within the 2WW target, with a median referral-to-clinic time of 12 days, meeting national access standards.
- Among the 11 confirmed cancer cases, the median time from referral to treatment was 70 days (clinic-to-treatment: 58 days), exceeding the NHS 62-day cancer treatment standard.

- While diagnostic steps were completed rapidly in the one-stop model, delays in treatment initiation contributed to longer referral-to-treatment times.

Conclusions

The one-stop PMB clinic model provides timely and accurate diagnosis while minimising the need for general anaesthesia through well-tolerated outpatient hysteroscopy. It supports early cancer detection through consultant-led outpatient services. Although endometrial thickness remains a useful triage tool, definitive diagnosis requires direct visual assessment and targeted biopsy. Most patients were seen within 2WW timeframes, though the overall referral-to-treatment interval for confirmed cancer cases exceeded national targets. This delay highlights system-level delays beyond the initial diagnosis. Limitations include the retrospective design, sample size, and single-centre setting. Larger prospective studies are warranted to validate these findings further and explore cost-effectiveness.

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Non-invasive testing for the diagnosis and monitoring of endometriosis - the way forward

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Background

Endometriosis is a common condition affecting 1 in 8 women of reproductive age. It is well documented that a patient will wait 8 years for a diagnosis. For majority of patients the disease is not visualised with either ultrasound or MRI and a laparoscopy is required. With laparoscopy there is a recognised high false negative rate and some patients are not suitable for surgery.

We present a new modality for the diagnosis and monitoring of endometriosis - The Endosure test.

The science behind the test was initially published in 1998. The discovery revealed that endometrial tissue releases large simultaneous amounts of prostaglandin PGE2 and PGFa, which have a seizure-like effect on the motility of the small bowel. This activity is known as gastrointestinal myoelectrical activity and is a newly described biomarker called the GIMA Biomarker. The GIMA Biomarker is detected by the currently approved device known as the Electroviscerogram or EVG. The EVG collects, records, and interprets the signal which is unique and present only in subjects with endometriosis or adenomyosis, and not found with any other diseases.

Methods

Participants aged 15 to 35 were recruited to the study with a history suggestive of endometriosis completing a standardised pain score.

Prior to test patients were asked to refrain from antispasmodics and opioid medication for two days. Patients were allowed sips of water only in the 8 hours prior to the test and nil by mouth 2 hours before. Three electrodes were placed on the abdomen and after a 10-minute baseline reading, the patient is given a standardised water load. The patient lies still for the 30-minute EVG were recorded using an FDA-cleared hand-held EVG device and respiratory belt to distinguish respirations from bowel contractions.

EVGSAS custom software was used to perform recording and data analysis of measurements of filtered percent distribution of power at 15–20, 20–30, 30–40, 40–50, and 50–60 cpm ranges during baseline recording and 10, 20, and 30 min after water load. These are the GIMA biomarker frequency ranges specific to endometriosis. A severity score indicative of their disease activity was calculated.

Ten participants were prescribed three months of Ryego and the standardised pain scores and tests were repeated.

Results

The ten participants reported subjective improvement in their pains scores following the three-month course of Ryeqo. This was mirrored with a decrease in their severity score on the repeat Endosure test. Details to follow

Conclusions

The advantages of a rapid and accurate non-invasive test with immediate results for endometriosis cannot be underestimated. The Endosure test will be extremely beneficial for younger patients and those not suitable for surgery. The Endosure test can be used to not only to diagnose but also to monitor the disease.

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Perforation of uterine integrity and migration of the intrauterine Device into the abdominal cavity

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Background

The intrauterine device is one of the most widely used reversible contraceptive methods in the world, with a Pearl Index ranging from 0.1 to 1.5 per 100 women per year. Despite its multiple advantages such as high efficiency, safety, long duration of use and rapid reversibility, one of the most serious complications is perforation and migration of the intrauterine device into the abdominal cavity. It may damage neighbouring organs as: intestine, bladder, rectum and urinary tract. It is a rare complication with an incidence between 0.12 and 1.6 perforations per 1000 insertions. we purpose to review cases of perforation of the uterus with intrauterine device, which is rarely described in literature, with description of clinical features, predisposing factors, complications and therapeutic approach

Methods

Identification of patients diagnosed with uterine perforation due to an intrauterine device, from the premises of IMSP SCM Gheorghe Paladi, during the year 2024.

Results

In the first case, the 33-year-old patient, multigestational (11 pregnancies), second childbearing (2 deliveries), it was presented with pain in the lower abdomen, which did not respond to anti-inflammatory drugs. From the anamnesis, three days after she had an IUD placed, after which the pain began. The patient underwent an abdominal X-ray, which revealed the IUD in the abdominal cavity. It was performed surgical laparoscopy with removal of the intrauterine device and diathermocoagulation of the defect.

In the second case, a 25-year-old patient, multipregnant (3 pregnancies), secundiparous (2 deliveries), was referred to the context of a positive pregnancy test. The patient reported that she had been wearing a copper IUD for 4 months. On USG examination: uterine pregnancy 6 s.a. The IUD was incorrectly placed in the vesicouterine space. It was performed surgical laparoscopy with removal of the intrauterine device from the rectouterine pouch.

In the third case, the 47-year-old patient, multipregnant (4 pregnancies) and multiparous (3 deliveries) had complaints of pain in the lower abdomen. The patient mentioned that she had been wearing an IUD for about 2 years. On USG examination: IUD incorrectly placed in the abdominal cavity. It was performed a surgical laparoscopy intraoperatively, it was visualized a defect in the uterine fundus, and in the abdominal cavity colonic damage with IUD and with involvement of the omentum in the process. The IUD was removed, and the patient had a stoma created by fellow surgeons.

Conclusions

In women with an anamnesis of intrauterine device insertion, if there is no evidence of intrauterine device removal, regardless of symptoms, it is recommended to perform imaging investigations to rule out possible migration of the intrauterine device into the abdominal cavity. The WHO recommends removing an incorrectly inserted IUD as soon as possible, even if the patient is asymptomatic, due to the high risk of possible adhesions and complications.

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Surgical Strategies for Preserving Ovarian Function in Endometrioma Management

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Background

Endometriomas, also known as ovarian endometriotic cysts, are a common manifestation of endometriosis, affecting a significant proportion of women during their reproductive years. Surgical intervention is frequently required for symptom management and fertility preservation in these patients. However, traditional surgical approaches, such as cystectomy or ablation, have been associated with a potential risk of compromising ovarian reserve and future fertility. This has led to a growing concern among clinicians and patients, emphasizing the need to identify and implement surgical strategies that can effectively treat endometriomas while minimizing ovarian damage and preserving reproductive capacity.

Methods

To address this critical issue, a comprehensive systematic review was conducted by searching multiple electronic databases, including PubMed, Embase, and Cochrane Library, for relevant studies published between January 2000 and December 2022. The search strategy focused on a combination of key terms related to endometriomas, ovarian cystectomy, ovarian reserve, fertility preservation, surgical techniques, and anti-Müllerian hormone (AMH). Randomized controlled trials, prospective cohort studies, and systematic reviews evaluating various surgical approaches and their impact on ovarian function preservation in endometrioma management were critically appraised and synthesized.

Results

The literature review identified minimally invasive laparoscopic cystectomy with meticulous surgical technique as a promising approach for preserving ovarian function in the management of endometriomas. Specifically, careful stripping of the cyst capsule and judicious use of haemostatic agents have been associated with better preservation of ovarian reserve markers, such as AMH and antral follicle count (AFC), compared to ablative techniques or open surgery. Prospective studies have consistently demonstrated significantly higher postoperative AMH and AFC levels following laparoscopic cystectomy with minimal electrocautery use, indicating better preservation of the ovarian reserve compared to cyst ablation or laparotomy. Additionally, the technique of ovarian tissue transposition may be beneficial in cases of large or deeply infiltrating endometriomas, as it can prevent inadvertent ovarian injury during the surgical procedure.

Conclusions

Based on the cumulative evidence from the reviewed literature, minimally invasive laparoscopic cystectomy with careful surgical technique, characterized by meticulous stripping of the cyst capsule and judicious use of haemostatic agents, appears to be the optimal approach for preserving ovarian function in endometrioma management. Ovarian tissue transposition may be considered as an adjunctive measure in select cases to further minimize the risk of ovarian injury. However, larger prospective studies with long-term follow-up are warranted to validate these findings and evaluate

the impact of these surgical strategies on fertility outcomes, live birth rates, and overall reproductive health in women with endometriomas.

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Laparoscopic preconceptional niche repair. Surgical technique and reproductive outcome – 400 cases in single centre - 15 years experience.

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Background

rate of Caesarean sections in our clinic is 35,5%. In 40% of delivery uterine scar is an indication for repeated C\S, also an infertility factor and can results in PAS – as a complication

Methods

from 2009 417 patients we operated by LS assess with big niche and RMT less 2mm. In all cases we perform Bettocchi hysteroscopy with concomitant ultrasound measurement niche characteristics and inner myometrium contractility.

Results

LS niche repair was done in 413 cases – 4 robotically. No conversions were detected. Estimated myometrial thickness before surgery was 1,5mm after- 9,8 mm. After 6 month of rehabilitation RMT decrease to 7,7mm. One case of recurrent niche was detected. At present time 187 pregnancies finished successful by scheduled C\S. One at 35 weeks due to preelamsia, 2 miscarriages at 2 trimesters. In 4 cases successful vaginal delivery after niche repair in LS groupe.

Conclusions

Ultrasound investigation of scar condition with hysteroscopy allowed to identify patients who should be treated preconceptionally due to big niche with excellent reproductive outcome by laparoscopic approach.

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Robotic-Assisted Excision of Ovarian and Umbilical Endometriosis in a Patient with a Ventriculoperitoneal Shunt: Case Report of a Unilateralis Sinistra Access Strategy

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Background

Ventriculoperitoneal shunt (VPS) placement is the standard treatment for hydrocephalus secondary to conditions such as infection, meningitis, tumours, trauma, or haemorrhage. Umbilical endometriosis, a rare extrapelvic form often linked to prior surgical sites, poses unique surgical challenges in patients with multiple VPS revisions. This case highlights the safety and precision of robotic-assisted surgery with the da Vinci system in managing endometriosis while preserving shunt integrity.

Methods

Case Presentation

A 27-year-old woman, gravida II para II, presented with suspected high-grade endometriosis involving the umbilicus and the right ovary. Her medical history included a VP shunt with four previous revisions, most recently performed laparoscopically in 2022. To guide surgical planning, an interdisciplinary consultation with the neurosurgical team at the University Hospital Zurich was conducted. An abdominal X-ray from September 2022 showed the shunt catheter entering the peritoneal cavity via the right upper abdominal quadrant, with no paraumbilical extension. Based on these findings, the surgical team deliberately avoided trocar placement in the right upper quadrant.

The patient underwent robotic-assisted laparoscopy using the da Vinci system. Access to the abdominal cavity proved technically challenging due to dense intraperitoneal adhesions, not likely related to her prior surgeries. To minimize the risk of damaging the VP shunt and to overcome the adhesions, a modified approach was chosen. One robotic trocar was placed via the umbilicus, and two trocars were placed on the left abdominal side, following a unilateralis sinistra access strategy. This approach allowed safe entry and optimal surgical access while avoiding the shunt trajectory.

Results

The procedure included adhesiolysis of the bowel, right salpingectomy, excision of right ovarian endometriosis, excision of umbilical endometriosis with umbilical reconstruction, intraperitoneal lavage, and placement of a Robinson drain in the pelvic cavity. The intraoperative course, postoperative hospital stay, and 4-week follow-up were all uneventful.

Conclusions

Robotic-assisted laparoscopy is a safe and effective option for patients with a VPS. With proper imaging and interdisciplinary planning, complex pelvic surgery can be performed without compromising shunt function. This case supports the use of robotic surgery in similar high-risk scenarios.

An informed consent form has been obtained from the patient.



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Iatrogenic Uterine Arteriovenous Malformation Following Caesarean Section and Hysteroscopic Management of Retained Products of Conception

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Background

Acquired uterine arteriovenous malformations are rare vascular anomalies that result from disruption of the normal vasculature. Risk factors include surgical trauma from procedures such as curettage, hysteroscopy, and caesarean delivery. Clinical presentation may vary from mild intermittent spotting to sudden, profuse haemorrhage. Timely diagnosis and treatment are essential to avoid severe morbidity and preserve fertility.

Methods

Case Presentation A 30-year-old woman underwent an emergency lower segment caesarean section for a non-reassuring foetal heart rate trace. Intraoperatively, an adherent placenta was noted. At eight weeks postpartum, she presented with abnormal vaginal bleeding. Transvaginal ultrasound suggested retained products of conception, and she underwent hysteroscopic resection using a MyoSure device. Histopathological analysis confirmed the presence of placental tissue.

One month later, she returned with sudden-onset, heavy vaginal bleeding. Her haemoglobin level was 71 g/l, and she required transfusion of two units of red blood cells. Repeat ultrasound showed echogenic fluid within the endometrial cavity but no evidence of retained products of conception. She was empirically treated for presumed endometritis, but symptoms persisted.

Computed tomography angiography revealed a focal area of arterial enhancement within the right anterior uterine wall, with an associated dilated and tortuous right uterine artery. Subsequent diagnostic angiography demonstrated multiple abnormal distal branches of the uterine artery with early venous filling, consistent with a uterine arteriovenous malformation. Bilateral uterine artery embolization was performed successfully.

Results

Discussion This case illustrates the development of an iatrogenic uterine arteriovenous malformation following caesarean section and hysteroscopic uterine surgery. A high index of suspicion is warranted when bleeding recurs following initial management of retained products of conception. Vascular imaging is essential for diagnosis. Uterine artery embolization is a safe and effective treatment that preserves fertility.

At three-month follow-up, magnetic resonance angiography confirmed resolution of the lesion with restoration of normal uterine vascularity. The patient remained amenorrhoeic while breastfeeding and experienced no recurrence of bleeding.

Conclusions

Persistent postpartum bleeding following uterine surgery should prompt consideration of arteriovenous malformation. Early recognition and multidisciplinary intervention can prevent life-threatening haemorrhage and support future reproductive health.

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Safety and Outcomes of Laparoscopic Myomectomy and Subtotal Hysterectomy with Morcellation

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Background

Laparoscopic subtotal hysterectomy (LASH) and laparoscopic myomectomy (LM) are increasingly adopted for the surgical management of benign gynaecological conditions such as fibroids, heavy menstrual bleeding (HMB), adenomyosis, and endometriosis. These procedures offer significant benefits over open surgery, including shorter hospital stays, reduced perioperative blood loss, lower postoperative pain, and quicker return to daily activities. Concerns remain regarding the safety of power morcellation, particularly in the absence of containment systems, due to the rare but serious risk of disseminating undiagnosed malignancies. This audit aimed to evaluate surgical indications, intraoperative variables, complication rates, and outcomes in patients undergoing LASH and LM, with a focus on morcellation practices and documentation quality.

Methods

A retrospective review was conducted of all LASH and LM procedures performed between 2017 and 2024 at a district general hospital. Data were collected from TrackCare hospital records and scanned operative notes. Parameters assessed included patient demographics, primary indications for surgery, intraoperative blood loss, surgical complications, histopathological outcomes, duration of hospital stay, use and type of morcellation (contained vs uncontained), and whether documentation met audit standards. Both qualitative and quantitative analysis of operative variables was performed, with particular attention to variations in surgical technique and postoperative care.

Results

92 LASH cases were analysed. The most common indication was HMB (55%), followed by HMB with pelvic pain or fibroids (17% each), and endometriosis (10%). Over half of the patients were aged >45 years. Minimal intraoperative blood loss (<200 mL) was reported in 55% of cases. The majority of patients had short hospital stays, with 57% discharged after one day, 30% after two days, and 13% discharged on the same day. In 61% of cases, LASH was combined with bilateral salpingo-oophorectomy (BSO), while 27% had ovarian conservation. No intraoperative or postoperative complications were reported, and all histology specimens were benign with no sarcomatous changes identified. Morcellation was used in all cases, but a containment bag was utilised in only one. In the LM subgroup (n=5, ages 32–43), large fibroids were successfully removed with no complications or malignancy. Two cases had incomplete or missing operative notes, highlighting issues in documentation quality.

Conclusions

This audit confirms that LASH and LM are safe and effective surgical options for the treatment of benign gynaecological pathology. Outcomes were favourable, with minimal blood loss, rapid postoperative recovery, and no recorded complications. However, the widespread use of uncontained morcellation raises important safety concerns, particularly in light of current guidance from regulatory bodies. The absence of sarcomatous pathology in this cohort is reassuring but should not preclude adherence to containment protocols in future practice. Improving documentation and implementing consistent use of containment systems for morcellation may enhance patient safety in laparoscopic gynaecological surgery.

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Indocyanine Green Fluorescence (ICG) Imaging for Ureteric Identification in Deep Infiltrating Endometriosis Surgery: A Review

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Background

Indocyanine green (ICG) has emerged as a valuable tool in the surgical management of complex endometriosis with various application. We conducted a literature review to evaluate the safety and utility of Indocyanine Green (ICG) fluorescence imaging in enhancing ureteric identification during surgery for deep infiltrating endometriosis (DIE), and the current clinical evidence supporting its application.

Methods

A targeted narrative review was conducted based on eight published studies that assessed the use of ICG in gynaecological surgery, with a focus on ureteric identification during DIE excision. Studies included prospective case series, proof-of-concept studies, and systematic reviews comparing intraureteral and intravenous ICG administration. Data on technique, ureteric visualisation quality, adverse events, and surgical outcomes were synthesised.

Results

Of the eight identified studies, six specifically focused on intraureteral ICG use in DIE surgery, while two addressed broader gynaecological contexts. Intraureteral ICG, delivered via cystoscopically placed ureteric catheters, enabled clear delineation of the ureters with minimal background signal, even in distorted anatomical fields. Intravenous administration was less specific but offered utility in perfusion assessment of the ureters to help detect ischemic injury during extensive dissection. No intraoperative or postoperative complications related to ICG administration were reported across all studies. Surgeons reported increased confidence, quick detection of ureters, reduced length of ureterolysis and overall reduction in operative time when using ICG-guided ureterolysis.

Conclusions

ICG fluorescence imaging is a safe and effective technique for ureteric identification in complex endometriosis surgery. Intraureteral administration offers superior visualisation, particularly in cases with significant anatomical distortion. These findings support wider adoption and further evaluation of ICG in advanced gynaecological surgical practice.

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Smooth Muscle Tumours of Uncertain Malignant Potential (STUMP): a double case report

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Background

Smooth Muscle Tumours of Uncertain Malignant Potential (STUMP) are tumours that cannot be diagnosed unequivocally as benign or malignant. They have similar pathological characteristics to leiomyosarcomas and do not satisfy histological criteria for leiomyoma. There are no specific ultrasound characteristics described for STUMP, therefore its diagnosis is most commonly done on histopathological analysis after specimen excision.

Since there are no established guidelines for diagnosis, treatment and follow-up of these tumours, its management remains a challenge. The current gold-standard for treatment is total hysterectomy, with or without bilateral salpingo-oophorectomy. Women who wish to preserve fertility can be offered myomectomy with posterior hysterectomy. Current (limited) evidence suggests a significant risk of recurrence (between 8,7 and 36,5%), supporting the indication for surveillance after surgical management, even though the adequate frequency remains undefined.

We report two cases of STUMP diagnosed at a secondary-care hospital.

Methods

Relevant data was obtained from the hospital database regarding two cases of STUMP diagnosed in the institution.

Results

Case 1

A premenopausal woman in her fifties was referred to Gynaecology for stress urinary incontinence and abnormal uterine bleeding (AUB). Physical examination and pelvic floor ultrasound evaluation confirmed stress urinary incontinence caused by urethral hypermobility and a grade 2 rectocele; gynaecological ultrasound revealed a myomatous uterus with the largest fibroid (FIGO 6 and measuring 6 cm) on the anterior wall exerting pressure on the bladder.

She underwent total abdominal hysterectomy with bilateral salpingectomy, posterior colporrhaphy and suburethral sling placement. Histopathology report mentioned multiple leiomyomas and the largest fibroid was compatible with STUMP. The patient is currently in her fifth-year post-diagnosis and maintaining biannual hospital follow-up with ultrasound and physical examination and yearly CT and/or MRI scan with no evidence of relapse.

Case 2

A premenopausal woman in her forties undergoing regular gynaecological surveillance for endometriosis, amenorrheic under dienogest, presented with new-onset AUB leading to anaemia. Gynaecological ultrasound evaluation revealed growth of a previously diagnosed fibroid (FIGO 2-5 and measuring 6 cm) with features suggestive of typical leiomyoma. Relugolix with estradiol and norethisterone acetate was prescribed but was unsuccessful in AUB control.

She underwent laparoscopic total hysterectomy with bilateral salpingectomy; histopathology report

revealed a diagnosis of STUMP in the mentioned fibroid. The patient is in her fourth month post-surgery and will maintain specialist gynaecological surveillance.

Conclusions

STUMP are rare and complex uterine tumours whose behaviour can be unpredictable, leading to a difficulty in establishing management protocols. Knowledge of these variants is important in clinical practice.

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Hysteroscopic tubal occlusion as a fertility-preserving alternative in patients with suspected pelvic adhesions and hydrosalpinges

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Background

To present a case series of women with hydrosalpinges and suspected pelvic adhesions in whom hysteroscopic tubal occlusion was performed as an alternative to laparoscopic salpingectomy prior to in vitro fertilization (IVF), and to evaluate the reproductive outcomes of this minimally invasive approach.

Methods

This case series includes six infertile women with a history of prior abdominal surgeries and bilateral hydrosalpinges diagnosed by hysterosalpingography (HSG). All patients were considered at increased risk for intra-abdominal adhesions due to past laparotomies or pelvic infections. Given these risks, laparoscopic salpingectomy was avoided, and hysteroscopic tubal occlusion was performed using bipolar coagulation with rollerball at the tubal ostia. Postoperative recovery was uneventful in all cases. Patients were enrolled in an IVF program within three months following the procedure.

Results

All six patients completed IVF cycles following hysteroscopic tubal occlusion. Three of the six patients achieved clinical pregnancies confirmed by ultrasound, both resulting in live births. One patient did not conceive after embryo transfer. No intrauterine adhesions or surgical complications were observed. This approach avoided abdominal entry and enabled safe progression to assisted reproductive treatment.

Hydrosalpinx negatively affects IVF outcomes by impairing implantation and endometrial receptivity. While laparoscopic salpingectomy remains standard, it may not be feasible in patients with prior abdominal surgery or suspected adhesions. In such cases, hysteroscopic tubal occlusion offers a minimally invasive alternative. In our series, two of three patients achieved live births after hysteroscopic occlusion and IVF, supporting previous findings on its feasibility.

Randomized and retrospective studies have reported comparable pregnancy outcomes between hysteroscopic and laparoscopic approaches in selected patients. Additionally, novel hysteroscopic devices such as fibered coils have shown encouraging results. Although some meta-analyses favour salpingectomy for slightly higher live birth rates, hysteroscopic techniques remain valuable when laparoscopy is contraindicated.

Our findings confirm that hysteroscopic tubal occlusion can be safely and effectively implemented in selected IVF candidates, especially those at risk for surgical complications.

Conclusions

Hysteroscopic tubal occlusion appears to be a feasible, fertility-preserving alternative to salpingectomy or tubal ligation in selected patients with hydrosalpinges and suspected pelvic adhesions. It minimizes surgical morbidity and offers favourable reproductive outcomes, including live births. Further studies with larger cohorts are needed to validate its efficacy and safety compared to laparoscopic approaches.

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Robotic Excision of Deep Endometriosis: A Conservative Approach

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Background

To standardize a conservative surgical technique for the excision of deep endometriosis in the rectovaginal area using the Da Vinci Xi robotic system, aiming to improve safety and reduce the risk of complications, particularly in cases with ureteral or nerve involvement.

Methods

This prospective study included 43 patients diagnosed with posterior compartment deep endometriosis. Preoperative assessment involved endovaginal ultrasound to evaluate lesion size, rectal wall infiltration, bowel lumen stenosis, and ureteral involvement. Patients with bowel lumen stenosis >80% and sub-occlusive symptoms were excluded. All procedures were performed using the Da Vinci Xi system. Indocyanine green (ICG) fluorescence (3 cc) was injected into the ureters pre-docking to enhance intraoperative visualization, without the use of ureteral stents.

The surgical approach began with retroperitoneal dissection, identifying and following the ureter from its origin at the external iliac artery to the site of endometriotic involvement. The pararectal fossa was opened to isolate the pelvic nerves and mobilize the rectum. Complete nodule shaving was performed using monopolar energy, including removal of the affected vaginal patch. The vaginal defect was closed with Vicryl 0 sutures. A bubble test was performed in all cases to assess bowel integrity.

Results

No intraoperative or postoperative complications were reported. One month postoperatively, patients reported significant symptom relief, particularly regarding dyspareunia. Long-term follow-up at 6 months, 1 year, and 2 years—performed by the same ultrasound operator—revealed no recurrences. The use of ICG fluorescence significantly improved intraoperative ureter identification, especially in the absence of tactile feedback, without increasing operative time.

Conclusions

A standardized robotic approach for the excision of rectovaginal deep endometriosis enhances surgical safety and reduces the risk of ureteral and nerve injury. Ureteral ICG fluorescence is a valuable adjunct in robotic surgery, offering clear anatomical visualization and supporting a conservative, surgical strategy. Bowel resection should be considered only in cases where signs of subocclusion are already present.

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Predictive and diagnostic value of pre-transfer thin endometrial thickness for placenta accreta spectrum in assisted reproductive technology pregnancies following operative hysteroscopy

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Background

To evaluate whether pre-transfer thin endometrial thickness (EMT) can predict placenta accreta spectrum (PAS) and related adverse maternal surgical outcomes in assisted reproductive technology (ART) pregnancies with a history of operative hysteroscopy for uterine anomalies, such as a dysmorphic or T-shaped uterus and/or treatment for uterine synechia.

Methods

This retrospective cohort study included 273 ART pregnancies following operative hysteroscopy for various indications. ROC analysis assessed the predictive performance of EMT for PAS, peripartum hysterectomy (PP-TAH), and severe peripartum haemorrhage (SPPH ≥ 2000 mL). Binary logistic regression identified endometrial thickness and hysteroscopy indications associated with PAS.

Results

EMT ≤ 7.6 mm strongly predicted PAS (AUC = 0.858, 95% CI: 0.784–0.933; $p < 0.001$), with sensitivities of 91.4% and specificities of 81.9%. Similar thresholds predicted PP-TAH (AUC = 0.854) and SPPH (AUC = 0.824), with NPVs exceeding 98%. Among hysteroscopy indications, submucous myomectomy demonstrated the highest PAS risk (OR: 11.429; $p = 0.002$), followed by a T-shaped uterus (OR: 10.0; $p = 0.024$); however, uterine septum resection (OR 4.286; CI: 0.709–25.911; $p = 0.113$) did not significantly increase the risks.

Conclusions

Pre-transfer endometrial thickness (EMT) is a reliable predictor of PAS and associated maternal morbidity in ART pregnancies following operative hysteroscopy. Specific hysteroscopic indications, particularly submucous myomectomy, T-shaped uterus, and endometriosis, are independently associated with a significantly increased risk of PAS. These findings support the integration of EMT measurement and hysteroscopic indication profiling into individualized antenatal risk stratification.

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Comparison of Clinical and AI-Based Interpretation in Non-Stress Test (NST) Classification: Agreement and Diagnostic Consistency

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Background

Artificial intelligence (AI)-based models trained on large datasets and advanced algorithms employ signal processing and pattern recognition techniques to reduce subjectivity and human error in the evaluation of Non-Stress Tests (NST). A standardized three-tier NST classification system was introduced to improve consistency. This study aimed to examine the agreement between NST evaluations performed by clinicians and those generated by ChatGPT, a large language model-based artificial intelligence system, and to demonstrate its potential role in perinatal decision support through statistical agreement measures.

Methods

NST parameters were evaluated in two main groups—clinical interpretation and AI-generated interpretation by ChatGPT—in a cohort of 100 patients. Seven subcomponents were analysed, including overall NST categorization, variability, deceleration presence and type, acceleration and uterine contractions. Inter-rater agreement between clinician and ChatGPT evaluations was assessed using Cohen's Kappa coefficient across categorical variables.

Results

In the general patient population, good agreement was observed between clinician and ChatGPT evaluations (**Cohen's Kappa 0.655, Accuracy 77%**). Subgroup analyses showed moderate agreement in cases undergoing caesarean section due to foetal distress (**kappa 0.47, Accuracy 76%**), with ChatGPT classifying **87%** of these cases as Category 3. Notably, no patients in this subgroup were classified as Category 1 by ChatGPT, suggesting a conservative approach in high-risk scenarios. In the *non-reactive NST subgroup*, moderate agreement (**0.42**) was also observed. In all 9 cases of foetal tachycardia, ChatGPT correctly identified the condition (100% Accuracy) and classified 8 of them as Category 2.

When evaluating individual NST parameters, a very strong agreement was observed for the presence of accelerations (**0.84**). Good agreement was found in overall NST categorization (**0.64**), presence of decelerations (**0.79**), uterine contractions (**0.78**), and variability presence (**0.67**). In contrast, only moderate agreement was observed in the classification of deceleration types (**0.53**) and grading of variability (**0.47**) (Table 1).

Detailed comparison of *deceleration type* classification revealed weak-to-moderate agreement (**0.29**). "**Deep prolonged**" decelerations were consistently recognized by both evaluators, whereas significant discrepancies were noted in identifying "recurrent late," "deep late," and "variable" patterns. These results indicate that while AI shows acceptable performance in general pattern recognition, its ability to distinguish specific and complex patterns remains limited.

Table 2: Agreement Between Clinical and ChatGPT Evaluations

NST Parameter	Cohen's Kappa	Interpretation	NST Parameter	Cohen's Kappa	Interpretation
Acceleration (presence)	0.84	Very good	Variability (presence)	0.67	Good
NST Category (1–2–3)	0.64	Good	Variability grading	0.47	Moderate
Deceleration (presence)	0.79	Good	Deceleration type	0.53	Moderate
Contraction (presence)	0.78	Good			

Conclusions

This study demonstrated **moderate agreement** between AI and clinical evaluations in overall NST categorization. These findings suggest that while AI systems may be reliable for general risk classification, their performance in complex pattern analysis is limited. Consequently, clinical judgment remains indispensable, and AI tools should be regarded as complementary aids rather than standalone diagnostic solutions, especially in high-risk scenarios.

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Estimation of haemoperitoneum in patients with apoplexy ovary

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Aim

The aim of our study was to identify ultrasound signs that provide an opportunity to estimate the volume of hemoperitoneum in patients with apoplexy without resorting to surgery.

Background

The volume of haemoperitoneum is the decisive factor for surgical treatment in patients with apoplexy ovary. Provided the stability of hemostasis an organism could absorb 150-200 ml of intra-abdominal blood, so in cases where the volume of haemoperitoneum is less than 200 ml, conservative treatment can be allowed. Whereas laparoscopy enables to accurately (100%) estimate the volume of intra-abdominal bleeding, it is surgical intervention that leads to carboxyperitoneum and can create risks for patients.

Materials / Patients

A single-centre study at the Military Hospital (Southern Region, Odessa) included 140 reproductive-age women with ovarian apoplexy treated laparoscopically. Patients were grouped by haemoperitoneum volume: Group I (n=67, ≤200 ml), Group II (n=43, 200–500 ml), Group III (n=30, ≥500 ml). Transvaginal ultrasound (ALOKA-1100, SA-8000 SE, 6.0–7.5 MHz) in the sagittal plane assessed fluid level relative to the uterus. Echograms were classified as: Type 1 – fluid at/below isthmus (<50 ml); Type 2 – mid-uterus (50–200 ml); Type 3 – above fundus (200–500 ml); Type 4 – fluid around ovary/vesicouterine space, floating uterus (>500 ml). Ultrasound data were compared with laparoscopic findings.

Methods / Results

Results: In women with haemoperitoneum up to 200 ml and less on echograms the fluid level did not rise above the internal os of the cervix (type 1). In group 2, more than half patients had echograms type 2 - the free fluid level in the middle of the uterus. 2/3 of women with haemoperitoneum 500 ml and more corresponded to type 3 echograms (on the level or upper than fundus of uterus). In 25% of women, hyper echoic free fluid was detected in the vesicouterine space and around the ovaries, with corresponded to type 4 echograms.

Discussion

The correlation between the echographic distribution of fluid and intraoperative findings emphasizes the diagnostic value of transvaginal ultrasound in the evaluation of hemoperitoneum. In particular, the detection of type 1 or 2 patterns may justify conservative treatment in hemodynamically stable patients, avoiding unnecessary surgical risks. Conversely, type 3 and 4 patterns, especially in the presence of a floating uterus or echogenic fluid, indicate significant bleeding and require timely surgical intervention. These findings support a tiered approach to treatment planning based on non-invasive imaging.

Conclusion

We recommend using on an ongoing basis a vaginal ultrasound examination in sagittal plane with the estimation of haemoperitoneum as a non - invasive method in case of ovarian apoplexy. It allows to select patients for conservative or surgical treatment.

Impact to Patients' Health

This approach contributes to the development of evidence-based, patient-centred medicine, reducing overtreatment and associated healthcare costs, while preserving reproductive health.

Four Cases of Ovarian Torsion Following Total Laparoscopic Hysterectomy (TLH) at a Single Institution and Their Management

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Background

Ovarian torsion following total laparoscopic hysterectomy (TLH) is a rare but increasingly reported complication, likely due to the growing adoption of minimally invasive surgery. We report four cases of ovarian torsion post-TLH at a single institution, focusing on the surgical context at the time of TLH and the subsequent onset of torsion.

Methods

We reviewed cases of postoperative ovarian torsion in patients who underwent TLH between 2012 and 2024. We evaluated patient age at the time of TLH, presence of endometriosis, interval between TLH and torsion onset, laterality of the affected adnexa, and the surgical procedures performed for torsion. We also discuss potential preventive strategies based on our findings.

Results

During the study period, 3767 TLHs were performed, and four cases of ovarian torsion were identified. The incidence rate was 0.1%. The mean age at TLH was 43.0 years; one patient had endometriosis. The mean interval from TLH to torsion onset was 14.3 months. Torsion occurred on the right side in three cases and on the left in one case. Three patients underwent adnexectomy, and one underwent detorsion with ovarian fixation. All four cases involved ovaries with a high degree of mobility.

Conclusions

We encountered four cases of ovarian torsion following TLH. The timing of onset, patient age, and torsion laterality were consistent with previously reported data. Anatomical changes associated with laparoscopic surgery—such as extensive retroperitoneal dissection for ureteral identification and isolation of the infundibulopelvic ligament—may increase ovarian mobility and predispose to torsion. The higher incidence on the right side may be due to restricted mobility on the left from sigmoid colon adhesions. Preventive measures may include minimizing retroperitoneal dissection and considering ovarian fixation. We have now adopted ovarian fixation at our institution to reduce the risk of torsion.

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Surgical approaches of anterior and apical prolapse treatment

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Background

Combined descent of anterior and apical compartments is observed in its every 5th case of genital prolapse, making it a widespread challenge for surgical management. Ath of methods' evolution went through autologous fascia reinforcement to polypropylene insertion. At first, the latter type of surgery was met as a modern solution for all colporrhaphy limitations but now is being prohibited in many countries for its hard treatable mesh-related complications. Nevertheless, there is a lack of surgical alternatives of that technique in case of severe anterior-apical prolapse.

Methods

Multicentre prospective study was conducted on 238 patients with III-IV grade combined anterior-apical prolapse with the absence or grade I asymptomatic posterior prolapse, that underwent surgical correction during 2013-2024 yy. In 1st group (n=134) vaginal colpopexy using OPUR kit was performed; 2nd group (n=104) of patients underwent sacrocolpopexy. Long-term assessment included observation of patients annually after surgery including bimanual examination and validated questionnaires (PFDI-20, PFIQ-7, PISQ-12) for anatomical and functional outcomes respectively.

Results

Average follow-up was 54,2±15,8 and 60,0±9,3 months in I and II group respectively. Anatomically we observed 6,0% of recurrence in transvaginal mesh group and 16,3% in sacrocolpopexy. All of recurrence cases in the 2nd group were presented as cystocele, but in the 1st group indirect prolapse formation was observed more often (5,2%). According to questionnaires, the 1st group showed better subjective outcomes in symptom relief (96,3 vs 82,7%) and social life improvement (91,0 vs 78,8%), but the 2nd group showed better sexual life refinement (80,6 vs 94,2%). During long-term outcome assessment, 4 (3,0%) cases of mesh erosions (3 located at the vaginal wall and 1 extrusion in the bladder) were observed, all of which were in the transvaginal mesh group.

Conclusions

patient selection for each surgical route should consider next points:

- 1) Co-morbidity that can serve as contraindications for different patient positioning or anaesthesia during the intervention.
- 2) Prior prolapse surgery: in cases of recurrence after sacrocolpopexy it's preferable to perform transvaginal mesh and vice versa. The vault prolapse cases are better to be treated laparoscopically.
- 3) Type of Halban's fascia defect: sacrocolpopexy can't adjust lateral defects the way vaginal mesh does.

4) Prevalence of anterior vaginal wall defect relatively to apical: if the last one is the most descent the sacrocolpopexy is preferable and vice versa.

5) Age of the patients and their social and sexual preferences.

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Vaginal and abdominal routes in the treatment of apical pelvic organ prolapse

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Background

Despite the excessive advancements in reproductive gynaecology, pelvic floor dysfunction (PFD) is still the problem, that comes always nearby. Its association with pregnancy and labour is a matter of fact, hence, with elevating reproductive success rates gynaecologists should be prepared for an increase in pelvic organ prolapse (POP) prevalence in near future.

Although cystocele appears to be the most frequently recognized type of POP, most women who suffer from cystocele at or beyond the hymen typically also have a concomitant loss of apical support. Since there are no guidelines to show, which apical support procedure should be performed, more studies should be performed to make it clear.

Methods

Multicentre longitudinal study was conducted on 288 patients with III-IV grade apical prolapse (excluding vault prolapse) with absence or grade I-II anterior or posterior prolapse, that underwent genital prolapse surgery during 2013-2024 yy. Women were divided into two groups: in 1st group (n=151) anterior bilateral mesh SSF was performed; in 2nd group (n=137) performed SCP laparoscopically or robotically with concomitant subtotal hysterectomy. Long-term assessment included observation of patients each year after surgery including bimanual examination and validated questionnaires (PFDI-20, PFIQ-7, PISQ-12) for anatomical and functional outcomes respectively.

Results

Average follow-up was 35,3±14,6 and 62,3±27,7 months in I and II group respectively. There was 2,6% of apical prolapse recurrence in SSF group and 2,2% in patients after SCP. According to questionnaires and their minimal clinical important difference results, both groups showed comparable sexual life improvement (88,1% and 94,9% according to PISQ-12 questionnaires in I and II group respectively) and I group showed better pelvic floor dysfunction symptom relief and social life improvement (88,7% for the PFDI-20 and 83,4% for the PFIQ-7) comparing to results in II group (81,8% for the PFDI-20 and 79,6% for the PFIQ-7).

Conclusions

Patient stratification should be considered according to the next points:

- 1) Co-morbidity that can serve as contraindications for Trendelenburg patient positioning or anaesthesia type during the intervention.
- 2) SCP can be preferable in women with concomitant indications to laparoscopy, SSF is a good option if perineoplasty is also planned.

3. 3) It's preferable to perform secondary POP surgery by a different route, if the previous one was failed.
4. 4) Patient's intentions for preserving the uterus.
5. 5) Age of the patients, their social status and sexual activity.

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V-NOTES in Practice : Initial Experience and Early Outcomes

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Background

Vaginal Natural Orifice Transluminal Endoscopic Surgery (V-NOTES) is an emerging minimally invasive technique that combines the benefits of vaginal and laparoscopic surgery. It eliminates abdominal incisions, potentially reducing pain, recovery time, and visible scarring. We present our initial experience with v-NOTES at our institute.

Methods

The journey began with visit to a specialised V-NOTES centre, where members of our surgical team engaged in hands-on training. Following this, we collaborated with a V-NOTES surgeon who provided on-site proctoring and supervision during our initial cases, ensuring safety.

We developed a comprehensive business case outlining the clinical benefits, cost implications, equipment needs, and training requirements approved by the hospital's governance committee, enabling the acquisition of specialized V-NOTES equipment and formal adoption of the procedure.

We analysed initial 11 consecutive patients who underwent V-NOTES surgery between March 2023 and May 2025 at Norfolk and Norwich University Hospital. Data on demographic characteristics, indication for surgery, operative time, blood loss, hospital stay, and intra- and post-operative complications were collected.

Results

The mean age of the patients was 48 years, with a BMI range of 26–41 kg/m². Surgical indications included heavy menstrual bleeding (n=9) and postmenopausal bleeding (n=2). None of the patients had prolapse/uterine descent or had a history of caesarean section and parity ranged from 2 to 4. The mean operative time was 108 minutes, with an average estimated blood loss of 86ml. There were no major intraoperative complications or conversions to open surgery. The uterine size ranged from 7 to 12 cm and benign pathology was confirmed in all cases with histology.

One patient developed a postoperative urinary tract infection, which was managed conservatively with oral antibiotics. The mean length of hospital stay was 1.2 days. Of the 11 patients, 6 were successfully discharged on the same day of surgery and enrolled on virtual ward.

All patients received an intraoperative pudendal nerve block and postoperative analgesia consisting of paracetamol, ibuprofen, and/or codeine. No patients required readmission for pain or other complications.

Conclusions

Our initial experience demonstrates that V-NOTES is a feasible and safe surgical option for selected patients undergoing hysterectomy and adnexal surgery, offering promising outcomes with minimal complications. We have extensive experience with vaginal hysterectomies for non-descent uteri,

consistently achieving excellent clinical outcomes and discharging the majority of patients within 24 hours. However, a key limitation of the traditional vaginal approach is the inability to visualize the peritoneal cavity directly, making it difficult to perform salpingectomy or oophorectomy, necessitating additional abdominal incisions for laparoscopic port placement, thereby increasing operative time and postoperative pain. The absence of visible scarring, low postoperative pain, and short hospital stays with v-NOTES are notable advantages. Importantly, no conversions or major complications were observed in this pilot series, highlighting the safety of V-NOTES in appropriately selected patients.

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From Misdiagnosis to Massive Haemorrhage: Managing Advanced Ovarian Ectopic Pregnancy at 13 Weeks

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Background

Ovarian ectopic pregnancy (OEP) occurs in 0.5-1% of ectopic pregnancies, presenting a major diagnostic and surgical challenge (Almahloul et al., 2023). The aim of this case report is to document a rare case of advanced OEP that reached 13+6 weeks gestation, analyse the diagnostic challenges encountered despite multiple healthcare visits, and highlight critical elements for early recognition and management of this life-threatening condition.

Methods

A 39-year-old G5P4 presented to the emergency department (ED) with severe abdominal pain and a one-day menstrual period 3 months prior. Clinical assessment, laboratory tests, and multiple ultrasound examinations were performed. The diagnostic process, surgical management, and outcomes were analysed alongside a review of current literature on OEP detection and management.

Results

Initial presentations were misinterpreted as constipation despite tachycardia (130 bpm), abdominal distension, and abnormal laboratory values (haemoglobin 89 g/L, white cell count $19 \times 10^9/L$, CRP 26 mg/L). Multiple ultrasound scans incorrectly identified an intrauterine pregnancy before a comprehensive examination revealed a left adnexal ectopic pregnancy with foetal cardiac activity at 13+6 weeks. Significant hemoperitoneum indicated rupture.

Surgical intervention confirmed a ruptured left OEP (10x6 cm) with 3 litres of haemoperitoneum. Laparoscopic left salpingo-oophorectomy was performed. The procedure was complicated by 4-liter blood loss requiring massive transfusion of 6 units of blood and 6 units of fresh frozen plasma. Preoperative haemoglobin had dropped to 50 g/L. Histopathology confirmed the OEP diagnosis.

Conclusions

This case demonstrates the diagnostic challenges of OEP, with preoperative detection rates varying widely in literature (0-75%) (Melcer et al., 2015; Odejinmi et al., 2009; Solangon et al., 2024). Successful diagnosis requires a systematic ultrasound approach that includes evaluation of the cervix, endometrial cavity, and uterine fundus (Doubilet et al., 2013; Salomon et al., 2013). Key diagnostic features include gestational tissue embedded within ovarian stroma and negative sliding sign between pregnancy and ovary during manipulation (Jurkovic & Mavrellos, 2007). Regarding treatment, maintaining ovarian tissue integrity is preferable, with oophorectomy being reserved for cases of uncontrollable haemorrhage (Ge et al., 2019).

The misdiagnosis of this advanced OEP despite multiple healthcare encounters underscores the importance of following standardised ultrasound protocols. Early recognition through proper

technique is essential to prevent life-threatening complications and enable timely intervention before catastrophic rupture. Moreover, laparoscopic management, when feasible even in cases with significant haemorrhage, offers superior patient outcomes with reduced morbidity, shorter hospital stays, and faster recovery compared to laparotomy.

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Dual Rarity: Successful Management of Molar Pregnancy in Unicornuate Uterus Rudimentary Horn

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Background

The unicornuate uterus with a non-communicating rudimentary horn represents a rare variant, occurring in approximately 1 in 4,000 women (Grimbizis et al., 2013). The combination of a molar pregnancy within a non-communicating rudimentary horn represents an infrequent entity with very few cases reported in the literature (Oskovi Kaplan et al., 2018; Si et al., 2017). This case report aims to analyse the diagnostic challenges presented by this complex Müllerian anomaly and evaluate the surgical approach that led to successful resolution with fertility preservation.

Methods

We present a case study of a 33-year-old nulliparous woman who presented with a positive pregnancy test and mild abdominal cramping. Diagnostic evaluation included transvaginal ultrasonography (TVUS), serum human chorionic gonadotropin (hCG) measurement, and laparoscopic exploration. The management approach, surgical techniques, and outcomes were analysed with attention to the anatomical complexity and reproductive implications.

Results

Initial TVUS revealed no intrauterine gestational sac but identified a congenital uterine malformation consistent with a unicornuate uterus with non-communicating rudimentary horn (ESHRE/ESGE classification U4a). While no definitive gestational sac was visualised, the rudimentary horn showed trophoblastic reaction with a heterogeneous endometrial cavity. Serum hCG was markedly elevated at 112,054 IU/L with progesterone of 87nmol/L, raising suspicion of molar pregnancy.

Laparoscopic findings confirmed a left distended rudimentary uterine horn, 4x5 cm containing an ectopic pregnancy. The left rudimentary horn was attached to the main uterus via a vascular pedicle, with the left fallopian tube connected to the rudimentary horn. Both ovaries appeared normal with a corpus luteal cyst on the left ovary.

Surgical intervention involved excision of the left rudimentary horn and left salpingectomy using harmonic scissors without vasopressin or other haemostatic procedures. The uterine excision site was reinforced with polyglactin sutures. Blood loss was minimal (<100ml), and operative time was under 30 minutes. The patient was discharged the same day with uneventful recovery. Follow-up hCG decreased to 23 IU/L, indicating complete resolution.

Conclusions

This case highlights the diagnostic and therapeutic challenges of managing ectopic pregnancies in Müllerian anomalies, particularly when complicated by suspected molar pregnancy. Pathogenesis likely involved transperitoneal migration of sperm or fertilised ova, an unusual mechanism highlighting the complex interplay between anatomical anomalies and reproductive physiology.

Transvaginal ultrasonography played a crucial role in diagnosis, though limitations of 2D imaging in complex uterine anomalies were evident. The elevated hCG level provided important diagnostic clues suggesting molar changes. Early laparoscopic intervention with rudimentary horn excision represents the optimal approach, preventing potential catastrophic haemorrhage while preserving reproductive potential.

This case underscores the importance of maintaining high clinical suspicion for ectopic pregnancies in patients with uterine anomalies. It demonstrates that minimally invasive laparoscopic management provides excellent outcomes with rapid recovery, which is essential for women desiring future fertility despite the inherent risks associated with the unicornuate uterus in subsequent pregnancies.

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Isolated Right Tubal Torsion Without Ovarian Involvement: Laparoscopic Findings and Management

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Background

To report a rare case of isolated fallopian tube torsion in a middle aged woman, associated with a small paratubal cyst, and to highlight the diagnostic challenges and surgical management of this uncommon gynaecological emergency.

Methods

A 44-year-old female patient presented to the emergency department with acute onset of severe right lower abdominal and pelvic pain. Clinical examination revealed localized tenderness without peritoneal signs. Pelvic ultrasound showed a right adnexal cystic structure measuring 3 cm, with normal ovarian tissue. Due to worsening symptoms and inconclusive imaging, diagnostic laparoscopy was performed.

Results

Laparoscopic exploration revealed isolated torsion of the right fallopian tube, with no involvement of the ipsilateral ovary. A three centimetres paratubal cyst was identified as the likely etiological factor. The fallopian tube appeared necrotic and non-viable. A right salpingectomy was performed. The ovary was preserved. Postoperative recovery was uneventful. Histopathology confirmed the presence of a benign paratubal cyst and fallopian tube necrosis.

Conclusions

- Isolated fallopian tube torsion is a rare but important differential diagnosis in women presenting with acute pelvic pain. It is often misdiagnosed preoperatively due to nonspecific clinical and radiological findings. Laparoscopy remains the gold standard for diagnosis and treatment. Early surgical intervention is essential to prevent complications such as tubal necrosis and to preserve ovarian function. Salpingectomy is indicated when the tube is non-viable. This case underscores the importance of considering isolated tubal torsion in the differential diagnosis of acute pelvic pain, even in the presence of normal ovarian findings on imaging.

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Audit of Ectopic Pregnancy Management Outcomes in an Early Pregnancy Unit: A Single-Centre Analysis

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Background

This audit aims to evaluate the management of ectopic pregnancy (EP) in our Early Pregnancy Unit (EPU) during 2024, focusing on management approaches and patient outcomes.

Methods

Among 113 EP cases included, management decisions were guided by specific clinical criteria. The cases diagnosed with caesarean scar ectopic pregnancy underwent dilation and curettage under ultrasound guidance. Laparoscopic intervention was indicated for patients with preference to surgical management, live EPs, or signs of rupture. For clinically stable patients with ultrasound-confirmed EPs, management decisions were informed by serial hCG measurements taken 48 hours apart. Patients with initial hCG levels below 1000 IU/L or showing a $\geq 15\%$ decrease qualified for expectant management. Those with initial levels under 5000 IU/L, minimal decrease ($< 15\%$), or rising hCG were candidates for either intramuscular methotrexate (MTX) or surgery.

Results

The cohort distribution showed that 60 patients underwent primary laparoscopic surgical management (Group A). Expectant management was initiated in 31 cases, with only four requiring subsequent surgical intervention (Group B). Twelve patients received medical management with MTX, though one eventually needed surgery (Group C). In Group B, one patient eventually opted for laparoscopic management, in two cases there was ultrasound evidence of a growing ectopic pregnancy, and there was one case of leaking ectopic pregnancy on scanning. Median hCG levels at diagnosis varied significantly: 2340 IU/L for Group A, 182 IU/L for Group B, and 1030 IU/L for Group C. Success rates were notably high, reaching 87% for expectant management and 92% for medical management.

Conclusions

This audit demonstrates that careful patient selection and thorough counselling regarding management options can successfully reduce surgical interventions while maintaining excellent clinical outcomes. Nevertheless, our data confirms that laparoscopic intervention remains the cornerstone of management for patients with higher hCG levels, live ectopic pregnancies, or signs of rupture, providing definitive treatment while minimizing recovery time and preserving future fertility potential

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Precision Under Pressure: Hysteroscopic Morcellation Transforms Management of Persistent RPOC

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Background

Retained products of conception (RPOC) are a common complication following pregnancy, with prevalence rates ranging from 0.5% to 19%, depending on pregnancy duration, outcome, and management approach (Hamerlynck, Blikkendaal et al. 2013). This case report aims to document the successful management of RPOC using hysteroscopic morcellation with the TruClear™ system, analyse the advantages of this approach compared to traditional methods, and evaluate the clinical outcomes regarding efficacy, safety, and patient recovery.

Methods

We present a case study of a 42-year-old woman with a history of two caesarean sections who presented with abnormal vaginal bleeding four weeks in duration. She had experienced a first-trimester miscarriage six weeks before presentation, managed initially with evacuation of retained products of conception (ERPC). Clinical assessment, laboratory tests, ultrasonography, and hysteroscopic surgical intervention were performed. The management approach, surgical technique using the TruClear™ system, and outcomes were analysed.

Results

Despite a negative urine pregnancy test three weeks after initial ERPC, ultrasonography revealed persistent RPOC measuring 47mm in diameter with increased vascularity, explaining the patient's continued abnormal bleeding. Based on these findings, repeat surgical evacuation was recommended.

A hysteroscopic evaluation identified that RPOC adhered to the fundus and right endometrial wall. Using the TruClear™ morcellation system, the surgical team successfully removed 6300mm³ of tissue in a remarkably efficient procedure lasting only 10 minutes. The procedure was associated with minimal blood loss and no intraoperative complications.

The patient experienced an uneventful recovery and was discharged on the same day as the procedure. Follow-up assessment at three months post-procedure demonstrated normal endometrial appearance on ultrasonography with complete resolution of symptoms, confirming the effectiveness of the intervention.

Conclusions

This case demonstrates that hysteroscopic morcellation using the TruClear™ system represents an effective and safe method for managing RPOC when traditional methods have failed or in cases with specific clinical features such as adherent tissue. Unlike traditional dilation and curettage using vacuum aspiration or metal curettes, which carry up to a 40% risk of intrauterine adhesions (Hooker, Aydin et al. 2016), hysteroscopic treatment offers targeted removal of pathological tissue while preserving healthy endometrial lining.

The TruClear™ system's single-insertion design provides significant advantages, including enhanced visualisation through simultaneous aspiration of blood clots during tissue removal (Hamerlynck, van Vliet et al. 2016). This approach minimises operative time, reduces blood loss, and decreases the risks of uterine perforation and intrauterine adhesion formation. The favourable outcomes in this case—including same-day discharge, absence of complications, and complete resolution at follow-up—highlight the clinical value of hysteroscopic morcellation as an essential tool in managing RPOC, particularly in cases where precision and endometrial preservation are priorities.

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Pelvic inflammatory disease treated by laparoscopy-our experience

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Background

Pelvic inflammatory disease (PID) is a well-known gynaecological condition that affects women at different ages. The ethiological agents were long time ago described as Chlamydia or Mycoplasma, but also different types of other bacteria. The objective of the present study was to reveal the characteristic of severe pelvic inflammatory disease that imposed surgical intervention in our department.

Methods

A retrospective study was performed between 2022-2025 in Saint John Hospital, Bucur, Maternity and included the patients who were diagnosed with pelvic inflammatory disease acute or chronic and were treated with laparoscopy or laparotomy.

Results

The study included 133 patients with the diagnosis of chronic PID. A percentage of 46.7% were admitted for acute symptoms such as fever, pelvic pain and vaginal discharge. The treatment was initiated with triple antibiotics, but in 6 cases the severe symptom required emergency surgical interventions. In 3 cases the surgical team was multidisciplinary. Most interventions were laparoscopies in 63.5% cases, after the treatment of acute symptoms. We performed laparoscopic salpingectomy in 75.7% cases, and we identified Fitz-Hugh-Curtis Syndrome in 3 cases. There was an emergency adnexectomy in a septic patient.

Conclusions

Pelvic inflammatory disease is a pathology with increasing incidence in our clinic. The laparoscopy intervention became the gold standard treatment for chronic disease and in selected acute cases.

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Report of a case with complete septate uterus with cervical duplication and vertical vaginal septum: Hysteroscopic correction sparing the double cervix

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Background

A complete septate uterus is a rare Müllerian anomaly resulting from a failure of complete fusion of the Müllerian ducts, characterized by two endometrial cavities and often accompanied by cervical duplication. This condition can lead to infertility, recurrent miscarriage, and obstetric complications. Hysteroscopic resection is the gold standard for minimally invasive correction of the septum. In this report we present a rare form of uterine anomaly presenting with complete uterine and vaginal septum with cervical duplication where the correction of the uterine and vaginal septum was successfully performed, while preserving the double cervix to prevent cervical insufficiency

Methods

Case report.

Results

A 21-year-old nulliparous patient presented with primary infertility. Her history was unremarkable and irregular menstruation or pain; ovulatory dysfunction and partner-related infertility were excluded. 3D Transvaginal ultrasound and hysterosalpingography revealed a complete fundal septum with two separate cervical canals. During speculum examination complete vertical vaginal septum was detected. Under general anaesthesia, surgical correction of septum was planned. First, vaginal septum was cut up to the level of cervix. Thereafter, one of the cervical canals were dilated up to 9.5 mm Hegar dilators. The hysteroscope was introduced through this cervical canal. Delineating the upper and lower limits of the septum was not possible at this stage. The tubal orifice was identified and uterine wall on the opposite site of the tubal ostium was cut at midlevel. Thereafter the gradual resection of uterine septum was performed up to tubal ostium level on the upper side and to cervical level at the lower side using bipolar resectoscope. The hysteroscope was deliberately directed to unify the uterine cavity at a central opening, and resection was limited up to the point where the cervical canals converged. The cervical duplication was preserved to prevent cervical insufficiency in subsequent pregnancies. The patient was discharged after 6 hours. At follow-up ultrasound at first postoperative month, a single uterine cavity with a restored fundal contour was observed at 3D transvaginal ultrasound. At the two-month follow-up, a spontaneous pregnancy was noted and the patient delivered a healthy baby at 39 weeks of gestation by caesarean section.

Conclusions

Hysteroscopic resection of a complete septate uterus is a safe and effective procedure that improves fertility prognosis. Preserving cervical duplication is important to prevent cervical insufficiency and perinatal complications. Hysteroscopic septum resection is a common daily basis surgical procedure but, techniques that preserve a double cervix are limited in complete uterine septum cases with cervical duplication. In the case presented here, preservation of cervical integrity ended up with livebirth at term.

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Hysteroscopy for Mullerian Malformations-our experience

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Background

The surgical approach for uterine mullerian malformations has changed in time especially in women with infertility.

Methods

This study retrospectively evaluated the cases from our department to identify the hysteroscopic approach for mullerian uterine malformations.

Results

The study included 34 patients with the diagnosis of mullerian anomalies who underwent hysteroscopy between 2023-2025. A percentage of 56.7% were investigated for primary infertility. The procedure was operative hysteroscopy in 76.5% cases. The main diagnosis was U2A according to ESHRE classification. The resection of the uterine septum was performed in most of the cases using monopolar electroresection. The ultrasound was the gold standard diagnosis procedure in all cases, and it was used also for intraoperative or postoperative evaluation. We had no conversion in laparoscopy or laparotomy during the hysteroscopic procedure.

Conclusions

Mullerian malformations represent an incidental diagnosis at ultrasound routine evaluation of the related cause of infertility. Hysteroscopy is the most common procedure performed to solve the uterine septum and obtain a normal uterine cavity.

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Obstetric Outcomes Following Surgical Management of Histologically Confirmed Endometriosis: A Retrospective Case-Control Study

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Background

Endometriosis, affecting approximately 10% of women of reproductive age, is associated with impaired fertility and adverse obstetric outcomes. This retrospective case-control study aimed to evaluate pregnancy outcomes following surgical management of histologically confirmed endometriosis.

Methods

Over a 12-month period, 18 patients with surgically treated endometriosis were compared to 20 age-matched controls without endometriosis. Data collected included demographic characteristics, conception rates and pregnancy outcomes.

Results

Conception rates were higher in patients with Stage I and II endometriosis, suggesting better reproductive prognosis in early-stage disease. Term delivery was achieved in the majority of cases across all stages. Miscarriage was observed in 11.1% of the endometriosis group versus 27.8% in controls (mean miscarriage rate: 0.45 vs. 0.55). Ectopic pregnancy occurred in 11.1% (2/18) of the endometriosis group and none in controls. Birth weight was significantly lower in the endometriosis group (3.15 kg vs. 3.48 kg; $p = 0.0287$). Incidences of PET (11.1% vs. 5.5%), GDM (11.1% vs. 15%), and SGA (11.1% vs. 10%) were comparable between groups and not statistically significant.

Conclusions

Pregnancy following endometriosis may carry higher obstetric risk, underscoring the need for further large-scale studies to clarify these associations.

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Surgical Management of Suspected Ovarian Dermoid Cysts: Fifteen-Year Retrospective Study with Final Histopathological Correlation

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Background

Ovarian dermoid cysts (mature cystic teratomas) are among the most common benign ovarian neoplasms, yet their clinical, radiological, and biochemical heterogeneity complicates diagnosis. We assessed clinical features, diagnostic accuracy, operative trends, and peri-operative outcomes in patients operated on for lesions initially presumed to be dermoid cysts at a tertiary referral centre.

Methods

All consecutive patients undergoing surgical excision of ovarian cysts provisionally diagnosed as dermoid cysts between 2010 and 2025 were retrospectively reviewed. The retrospective data acquisition was approved by the hospital administration. Variables collected included age, year and type of surgery (laparoscopy or laparotomy), use of specimen retrieval bags, imaging findings, serum tumour markers (CA-125, CA19-9, AFP, CEA, CA15-3), intra-operative frozen section, definitive histopathology, cyst integrity, chemical peritonitis, and complications. The Shapiro–Wilk test assessed normality; categorical variables were compared with chi-square analysis (two-sided, $p < 0.05$).

Results

The cohort comprised 148 patients (median age 30 years, range 1 to 90; distribution non-normal, $p < 0.001$). Laparoscopic procedures increased from 25 percent in 2010 to 75 percent in 2025. Retrieval bag use began in 2013 and reached 75 percent by 2025. Cysts were removed intact in 110 cases (74 percent); rupture occurred in 38 (26 percent). Retrieval bags tended to reduce rupture, although not statistically significant ($p = 0.079$). The overall complication rate was 5.4 percent; chemical peritonitis was uncommon.

Final pathology identified malignancy in 23 lesions (15.5 percent). Frozen section correlated strongly with definitive histology (discordance 6.17 percent, all false negatives; $p < 0.000001$). Imaging findings did not predict malignancy ($p = 0.094$). Abnormal serum tumour markers correlated with malignancy ($p = 0.0025$); CA-125, CA19-9, and AFP showed moderate predictive value, whereas CEA and CA15-3 were non-informative. Rupture rates were similar in malignant (26.1 percent) and benign (25.6 percent) cases ($p > 0.05$).

Conclusions

Laparoscopic cystectomy with retrieval-bag extraction is the preferred fertility-preserving strategy in paediatric and adolescent patients and is increasingly adopted in adults. Frozen section remains a dependable intra-operative diagnostic adjunct. Serum tumour markers aid risk stratification, but imaging alone is insufficient; comprehensive intra-operative evaluation is essential. Ongoing multidisciplinary collaboration and refinement of minimally invasive techniques are likely to further

reduce rupture and complication rates while aligning management with patients' reproductive priorities.

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Evaluating Diagnostic Accuracy and Clinical Utility of Hysteroscopy: A Retrospective Analysis of 1016 Cases

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Background

Hysteroscopy is a minimally invasive technique used to evaluate endometrial, tubal, and endocervical pathologies via a transcervical approach, either for diagnosis or simultaneous treatment. This study aims to retrospectively analyse patients who underwent diagnostic and/or operative hysteroscopy to assess the reliability and diagnostic accuracy of the procedure in light of these results and in accordance with existing literature.

Methods

We conducted a retrospective analysis of 1016 patients who underwent diagnostic or operative hysteroscopy between January 2020 and September 2022 at the Department of Obstetrics and Gynaecology, Ankara University Faculty of Medicine. Patients aged 18–80 years, including reproductive, perimenopausal, and postmenopausal women, were included. Data collected included demographic characteristics, preoperative diagnosis, type of hysteroscopic procedure, operative details, complications, hysteroscopic findings, and histopathological results. Sensitivity, specificity, predictive values, and accuracy of hysteroscopic diagnoses were compared with histopathological findings.

Results

The mean age of the 1016 patients included in the study was 39.8 ± 10.9 years (range 19–78). Among these, diagnostic hysteroscopy was performed in 49 patients (4.8%), while operative hysteroscopy was conducted in 967 patients (95.2%). Primary infertility (28.6%) was the most common indication for diagnostic hysteroscopy, whereas endometrial polyp (28.2%) was the leading indication for operative procedures. The most frequent operative procedure was polypectomy (34.6%), followed by septum resection and uterine cavity optimization (15.0%). Complications occurred in 14 (1.4%) patients, including uterine perforation in 4 (0.39%), bleeding in 4 (0.39%), excessive fluid overload in 2 (0.19%), cervical laceration in 2 (0.19%), and postoperative infection in 2 (0.19%).

The leading hysteroscopic diagnoses were polyps (34.1%), uterine septum (19.1%), and uterine fibroid (9.7%). Histopathology confirmed endometrial polyps in 36.0%, leiomyomas in 9.4%, and chronic endometritis in 4.3% of cases.

When hysteroscopic findings were compared with histopathological results, the method showed a sensitivity of 79.8% and specificity of 91.7% for polyps, with positive and negative predictive values of 84.4% and 89.0%, respectively. For fibroids, sensitivity was 87.5%, specificity 98.4%, positive predictive value 84.8%, and negative predictive value 98.7%. Hysteroscopy demonstrated accuracies of 87.0% for polyps and 97.0% for fibroids. A significant correlation was observed between hysteroscopic and histopathological findings for both polyps ($p < 0.001$, $r = 0.72$) and fibroids ($p < 0.001$, $r = 0.84$).

Conclusions

Our study confirms the efficacy of hysteroscopy as a first-line approach for the management of abnormal uterine bleeding, infertility, and other uterine cavity disorders due to its high accuracy, specificity, and safety profile. When combined with histology, it remains the gold standard for intrauterine assessment and will continue to play a central role in gynaecologic practice.

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The practice of outpatient Hysteroscopy in a District General Hospital: Vaginoscopic Vs Traditional method.

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Background

Outpatient hysteroscopy is an established diagnostic and therapeutic procedure, widely used across the UK. The aim of the study is to determine the best approach of outpatient hysteroscopy (vaginoscopic vs traditional) in terms of pain, duration of procedure, feasibility, safety, and acceptability.

Methods

It is a prospective study to compare vaginoscopic Vs traditional method of performing outpatient hysteroscopy. Data was collected over a 8-week period through the feedback forms. Patients were requested to fill them out whilst they are in the recovery following the procedure.

Results

A total of 51 patients provided feedback during this period. Out of them, 27 procedures were performed by vaginoscopic approach and 24 were done by traditional approach by inserting a speculum. About 70% of the patients were postmenopausal referred for hysteroscopy for postmenopausal bleeding, rest were premenopausal requiring procedure for either heavy menstrual bleeding or intermenstrual bleeding. All the patients had successful diagnostic outpatient hysteroscopy. 3 out of 51 patients required repeat procedure for polypectomy which were performed in 2 stages as the polyps were too large to remove in a single attempt. All the patients received information on hysteroscopy procedure prior to the appointment. 70% of patients had oral analgesia prior to the procedure.

Outcomes of vaginoscopic approach – The average time taken to perform the procedure was 10.4minutes, average pain score in this group of patients was 6. Out of the total 27 patients, 20 patients would opt for outpatient hysteroscopy, 4 neither agreed nor disagreed and 3 would like a general anaesthetic hysteroscopy if needed in future.

Outcomes of traditional approach – The average time taken to perform the procedure was 13minutes, average pain score was 6. Out of the total 24 patients, 19 patients would agree for a repeat procedure in the outpatient setting and 5 patients neither agreed nor disagreed for outpatient hysteroscopy if required in future.

Conclusions

Both the pain scores and patient satisfaction were comparable in both the approaches i.e; vaginoscopic and traditional. However, the duration of the procedure is lower vaginoscopically compared to traditional method.

Vaginoscopic approach is particularly advantageous in people who cannot lie supine due to medical comorbidities (e.g. heart failure, respiratory disease etc.), are obese, who have acutely flexed uteri and in those who have restricted hip movement. Also beneficial, in nulliparous women, those who suffer from vaginismus, are virgo intact and/or suffer from genital tract atrophy.

Vaginoscopy should be the standard technique for outpatient hysteroscopy.

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Introducing vNOTES to Northern Ireland

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Background

vNOTES surgeries have never been performed in Northern Ireland. A small group of interested and motivated gynaecologists sought training in this innovative approach so as to offer a wider range of options to their patients. This poster will be a review of a small number of cases performed to date - addressing patient selection and feedback, outcomes and plans for the future.

Methods

Training was received in vNOTES over two days, following completion of online theory training. All surgeons are competent laparoscopic and vaginal surgeons. Initial cases were highly selected and performed with support from colleagues and industry. As this was a novel procedure within our jurisdiction, all cases were prospectively audited for outcomes.

Results

Results are still being gathered; however initial findings indicate that outcomes are comparable to laparoscopic hysterectomy or vaginal hysterectomy. We are examining complication rates, length of stay and patient feedback.

Conclusions

While this project is ongoing, it is encouraging to see innovation within gynaecological surgery. vNOTES offers a new approach with different benefits to tradition methods. As a group of surgeons, we feel it is worth exploring this novel approach and introducing it within our small jurisdiction.

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Age-specific Clinical Characteristics of Ovarian Teratoma and Associated Malignancies: a Single-Centre Study

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Background

Mature cystic teratoma (MCT) accounts for 10%–20% of all ovarian masses. Although usually benign, mature teratomas can be associated with malignancy, which may manifest as combined ovarian malignancy or result from malignant transformation. Therefore, early detection of malignant transformation or malignancy associated with MCT or immature teratoma is important. However preoperative imaging and biochemical findings are neither specific nor sensitive. Most of the previous studies on ovarian teratoma have focused on its clinical characteristics in younger women and associated malignancies in older women. In this study, we reviewed our experience of cases of ovarian teratoma treated at our institution to determine the age-specific characteristics of MCT and its associated malignancies.

Methods

The medical charts of 2181 patients with pathologically confirmed ovarian teratoma who underwent surgery at CHA Gangnam Medical Center between January 2008 and April 2019 were retrospectively reviewed after conducting ethical approval. Malignancies associated with ovarian teratoma were divided into immature teratoma, combined ovarian malignancy, and malignant transformation of MCT. Patients were categorized according to age and data including age at surgery, parity, BMI, size of the teratoma, preoperative CA-125 levels, CA 19-9 levels, previous surgical history for ovarian teratoma, preoperative symptoms, location of the ovarian cyst(s), presence of ovarian torsion, other associated ovarian pathology, and postoperative follow-up duration were collected from medical charts.

Results

In total, 2181 patients were treated surgically for ovarian teratoma during the study period. The median patient age was 30 years (range, 7–82) and the median follow-up duration was 10 months (range, 0–152). Most ovarian teratomas were detected incidentally, except in patients with abdominal pain who were under 20 years of age; torsion was significantly more common in this age group ($p<0.001$). Tumours were larger in the younger age group ($p<0.01$). The incidence of immature teratoma was 0.5% ($n=11$), that of combined ovarian malignancy was 0.4% ($n=9$), and that of malignant transformation was 0.4% ($n=9$). The median patient age was 24.0 years for immature teratoma and 27.0 years for combined ovarian malignancy. The most common cell type was mucinous borderline tumour (55.6%, $n=5$). The median patient age at the time of malignant transformation was 33.0 years, and the most common cell type was carcinoid tumour (77.8%, $n=7$).

Conclusions

In this retrospective review in a single institution, the clinical manifestations of ovarian teratoma varied according to age group, with younger patients being more likely to be symptomatic and to have larger, bilateral tumours. Although there was no statistical significance in relationship between

age and associated malignancy ($p=0.442$), most of the malignancies associated with ovarian teratoma were found in women of childbearing age. Given the possible association between malignancy and ovarian teratoma, surgeons should perform detailed preoperative evaluations, avoid intraoperative spillage, and perform intraoperative frozen biopsy when appropriate.

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robot-assisted bowel-sparing surgery in deep infiltrating endometriosis with gastrointestinal dysfunction: a case series

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Background

Deep infiltrating endometriosis significantly impairs quality of life, particularly when bowel involvement leads to symptoms such as chronic constipation, dyschezia and rectovaginal pain. robotic-assisted laparoscopic surgery offers enhanced precision and manoeuvrability in complex pelvic dissections, making it an ideal approach in bowel-sparing interventions for deep infiltrating endometriosis.

Methods

We present two clinical cases of deep infiltrating endometriosis with prominent bowel dysfunction symptoms.

The first patient was a 41-year-old woman with a history of laparoscopic left salpingo-oophorectomy due to endometriosis. despite prior endometriosis surgery, the patient continued to experience persistent pelvic pain, dyspareunia, dysmenorrhea, and defecation difficulties. on vaginal examination, a painful submucosal nodule was palpated on the left lateral vaginal wall, exerting traction on the cervix . pelvic magnetic resonance imaging findings were consistent with deep infiltrating endometriosis, revealing nodular lesions involving the cul-de-sac and vaginal wall. surgical management was planned following multidisciplinary evaluation by gynaecology, general surgery, gastroenterology, and radiology teams, she underwent robotic-assisted hysterectomy, a robotic-assisted total hysterectomy with right salpingectomy was performed, along with the resection of endometriotic nodules located in the cul-de-sac rectum and vaginal wall. at the postoperative 1-month follow-up, the patient reported significant improvement in constipation and defecation-related pain.

The second patient was a 43-year-old woman presenting with abnormal uterine bleeding, dyspareunia, dyschezia, chronic constipation, and rectovaginal pain and with pain radiating toward the anterior iliac region. she also had abnormal uterine bleeding due to adenomyosis. magnetic resonance imaging revealed a deep endometriotic nodule at the level of the cervix. following a benign endometrial biopsy, the patient was started on dienogest therapy, which led to a reduction in abnormal uterine bleeding but did not relieve her pelvic pain and bowel dysfunction. surgical management was planned following multidisciplinary evaluation, she underwent robotic-assisted hysterectomy, left salpingo-oophorectomy, right salpingectomy, and excision of the cul-de-sac endometriotic nodule and rectal nodules. at the postoperative 1-month follow-up, the patient reported significant improvement in constipation and defecation-related pain, as well as a notable reduction in the pain radiating toward the iliac crest.

Results

Both patients were successfully managed with robotic-assisted bowel-sparing surgery. No intraoperative complications occurred and no bowel resections were required in both patients. significant symptom relief was reported at 1-month follow-up.

Conclusions

In cases of deep infiltrating endometriosis with bowel dysfunction, a multidisciplinary approach and robot-assisted bowel-sparing surgery is a allow for effective lesion excision while preserving bowel integrity.

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Interstitial and cornual ectopic pregnancy - Methods of treatment

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Background

Interstitial and cornual ectopic pregnancies are rare ectopic pregnancies which require a careful diagnosis and management as they can have catastrophic consequences. We had 3 patients, 2 presenting with a suspected ectopic pregnancies and one with a possible miscarriage. At laparoscopy and surgical management of miscarriage under ultrasound (US) guidance, interstitial and cornual ectopic pregnancies were identified and managed laparoscopically on 2 cases and laparotomy in one case.

Methods

These were case series on management of interstitial and cornual ectopic pregnancies.

Results

Case 1:

A 26-year-old multiparous woman attended emergency department (ED), at approximately 7 weeks, following her last menstrual period, with right iliac fossa pain and vaginal bleeding. An urgent transvaginal ultrasound scan of pelvis diagnosed live ectopic pregnancy in the right adnexa, with moderate amount of free fluid in the pouch of Douglas. Patient underwent an emergency laparoscopy, and a right interstitial ectopic pregnancy was identified, with 600ml of hemoperitoneum.

Case 2:

A 32-year-old parous woman presented with right sided pelvic pain and an ectopic pregnancy was identified on US with a beta HCG of 5245 lu/l. At laparoscopy, a right interstitial pregnancy was identified.

In both the patients, both the fallopian tubes and ovaries were normal. After infiltrating diluted vasopressin around the ectopic pregnancy, the pregnancy site was incised with monopolar hook. Products of conception (POC) were removed, and incision site was sutured using monofilament barbed suture. The patients made full recovery and was followed up in the Early Pregnancy Unit with regular HCG levels to ensure complete resolution of pregnancy.

Case 3:

A 42-year-old parous woman presented with mild vaginal bleeding and was diagnosed with a possible miscarriage on US. In theatre under US guidance no POC was identified, and patient became unstable under anaesthesia. An urgent laparotomy confirmed a ruptured cornual ectopic pregnancy which was then repaired. Patient made an uneventful recovery after a brief stay in the intensive care unit.

Conclusions

Accurate diagnosis of interstitial and cornual ectopic pregnancy is challenging and will need three-dimensional ultrasound or MRI to confirm two-dimension ultrasound finding and to avoid misdiagnosis with early intrauterine or angular pregnancy. As it is a surgical emergency, it's management should not be delayed.

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Metastatic postpartum choriocarcinoma presenting with persistent vaginal bleeding and haemoptysis: a rare diagnostic challenge

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Background

Choriocarcinoma is a rare but aggressive form of gestational trophoblastic neoplasia (GTN), with an estimated incidence of 1 in 10,000 pregnancies. Diagnosis can be delayed when presenting features mimic common postpartum conditions.

Methods

A 41-year-old woman, eight weeks postpartum following caesarean section and sterilisation, presented with persistent vaginal bleeding and rising serum beta-human chorionic gonadotropin (β -hCG). Initial pelvic ultrasound suggested retained products of conception, prompting surgical evacuation. Concurrently, she reported haemoptysis. Initial CT pulmonary angiogram (CTPA) was negative for embolism, but chest X-ray revealed a solitary pulmonary nodule. Bronchoscopy showed airway bleeding with no identifiable source. Repeat CTPA demonstrated rapid development of multiple pulmonary nodules.

Results

The patient was urgently transferred to a tertiary Gestational Trophoblastic Neoplasia (GTN) referral centre, where she was diagnosed with stage III metastatic choriocarcinoma and admitted to the high-dependency unit. Induction chemotherapy with etoposide and cisplatin was initiated, followed by escalation to multi-agent EMA/EP and TP/TE regimens. Due to chemoresistance, treatment was modified to include pembrolizumab immunotherapy.

Conclusions

This case underscores the importance of maintaining a high index of suspicion for choriocarcinoma in postpartum women with atypical symptoms such as persistent bleeding and unexplained haemoptysis. Early recognition, rapid diagnostic escalation, and multidisciplinary coordination were pivotal to this patient's management. Clinicians should consider GTN in differential diagnoses when β -hCG is persistently elevated postpartum.

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Optimal Timing of Laparoscopic Intervention for Interstitial Pregnancy: A Comparison with Tubal Pregnancy

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Background

Interstitial pregnancy can cause severe haemorrhage when ruptured, making the timing of laparoscopic intervention crucial. This study aimed to compare the clinical characteristics of interstitial and tubal pregnancies managed by laparoscopic surgery to identify optimal timing and predictive factors for surgical intervention in interstitial pregnancy.

Methods

We conducted a retrospective study of 157 ectopic pregnancy cases (11 interstitial pregnancies and 146 tubal pregnancies) that underwent laparoscopic surgery at our institution between January 2012 and December 2023. Patient backgrounds (age, BMI, gestational age at diagnosis, β -hCG levels, history of salpingectomy, and clinical symptoms), rupture rates, and surgical outcomes (operation time, intraoperative blood loss, intraperitoneal bleeding volume, conversion to laparotomy, and postoperative complications) were analysed.

Results

The interstitial pregnancy group had a significantly higher rupture rate compared to the tubal pregnancy group (36% vs 6.8%, $p=0.009$), with all ruptures occurring before 6 weeks of gestation. The interstitial pregnancy group had a significantly higher rate of previous salpingectomy (63% vs 6%, $p<0.001$), and all ruptured cases had a history of ipsilateral salpingectomy. β -hCG levels were significantly higher in the interstitial pregnancy group (median 9699 vs 4577 μ /L, $p=0.02$). Notably, while non-ruptured interstitial pregnancies had higher β -hCG levels than tubal pregnancies, there was no significant difference between the groups in ruptured cases. Laparoscopic surgery was successfully completed in all cases. Intraperitoneal bleeding in ruptured cases tended to be higher in the interstitial pregnancy group, particularly in cases with previous salpingectomy.

Conclusions

Interstitial pregnancies have a higher risk of rupture before 6 weeks of gestation compared to tubal pregnancies, especially in cases with previous salpingectomy where implantation occurs in the ipsilateral interstitial portion. While β -hCG levels may serve as a diagnostic indicator for interstitial pregnancy, they may not be predictive of rupture. These findings suggest the necessity for early and proactive laparoscopic intervention in interstitial pregnancies, particularly in cases with a history of salpingectomy, regardless of β -hCG levels.

<https://esge.covr.be/cmdocumentmanagement/conferencemanager/documents/api/getdocument/14545/cmabstsms/0000165210/dd3262d583e94059bf5bb9210907e0f0efebc523b1c812a1e20a5b11b63b95d8>

Surgical Approaches in Women with Preoperatively Diagnosed Low-Risk Endometrial Cancer: A Single-Institution Retrospective Study of Minimally Invasive Surgery versus Laparotomy

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Background

Minimally invasive surgery (MIS) has become an accepted treatment option for presumed low-risk endometrial cancer; however, the choice of surgical technique varies between institutions. This study aimed to evaluate the outcomes and surgical approaches for MIS in preoperative diagnosed low-risk endometrial cancer at our institution.

Methods

We retrospectively reviewed patients who underwent MIS for preoperative diagnosed low-risk endometrial cancer (endometrioid G1 or G2, stage IA) between 2014 and 2021. Recurrence-free survival (RFS) and overall survival (OS) were compared between MIS (n=113) and laparotomy (n=44). Additionally, within the MIS group, comparisons were made between patients who underwent simple hysterectomy (SH, n=77) and modified radical hysterectomy (MRH, n=36), and between those with <10 pelvic lymph nodes dissected (n=79) and ≥10 nodes dissected (n=34).

Results

Median age was 57 (range: 31–84) years, with a median follow-up of 62 months (range: 52–79). Endometrial curettage was performed in 75% of cases.

Five-year RFS and OS were 95% and 99%, respectively, with 7 recurrences observed.

Histology showed G1 in 112 cases, G2 in 32 cases, and histological upgrade in 9 cases (5.8%). Risk classification was revised postoperatively in 31 cases (19.7%), with 26 receiving adjuvant chemotherapy. No significant difference in recurrence outcomes was observed between MIS and laparotomy. Tumour diameter ≥3 cm may be a potential risk factor for recurrence.

Among MIS patients, no significant difference in prognosis was noted between SH and MRH groups (5-year RFS: 95% vs. 97%, OS: 100% vs. 97%). Similarly, lymph node dissection of <10 vs. ≥10 nodes did not significantly affect recurrence (5-year RFS: 67% vs. 97%).

Conclusions

Minimally invasive surgery is a valid approach for preoperative diagnosed low-risk endometrial cancer, with simple hysterectomy considered sufficient. Comprehensive endometrial curettage allows accurate histological diagnosis. In cases with small tumour size and minimal myometrial invasion, lymphadenectomy may be omitted.

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vNOTES and Oncologic Surgery: Another Ally to Consider

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Background

Our main objective is to demonstrate that the endoscopic vaginal route (VNOTES) is an alternative to consider for certain indications in oncological endoscopic surgery, specifically in selective sentinel lymph node biopsy, with great advantages in its reliability and safety. We are aware that VNOTES surgery cannot yet be considered a standard in gynaecological oncological surgery. The current evidence is type IIA, based on case series, with an expected immediate future of IIB evidence with multicentre and subsequently randomized studies. Baekelandt (2024) presents the first multicentre and prospective case series and Huber (2024) has published a 10-step approach.

Methods

Between 2023 and 2025, a total of 31 cases of oncologic surgery using VNOTES were performed at our centre. Sixteen cases involved early-stage endometrial carcinomas, five involved EIN, eight involved high-risk oncological patients, and two involved STUMP. A total of 18 cases of selective pelvic sentinel lymph node biopsy were performed. The procedure can be performed via a medial vaginal approach or a lateral vaginal approach. In our case, we preferred to perform it via the lateral vaginal approach. One of the characteristics of the lateral vaginal approach is its usefulness in narrow and deep vaginas. In the medial approach, a vesicovaginal dissection is performed similar to that performed in an anterior colpotomy. It is easier in patients with early stages of cystocele, and the lateral dissection is similar to that performed in a transobturator tension-free tape.

Results

It is important to properly inject the dye, empty the bladder beforehand, perform a proper blunt dissection of the retroperitoneal space, and correctly locate the obturator nerve, external iliac vein, and external iliac artery, as well as avoid medial manipulation of the retroperitoneal space. One of the most important advantages is that we follow the natural path of the lymph nodes from caudal to cranial. Retroperitoneal access is feasible even with preexisting adhesions. It can be a safe, reliable, and reproducible technique for experienced surgeons.

Conclusions

Although we are aware that current evidence does not yet allow the VNOTES approach to be considered a standard in oncologic surgery, there are many reasons to believe it could become a complementary approach in certain situations such as surgeries to reduce cancer risk. It can reduce complications and shorten recovery time for our patients. And its application to selective sentinel lymph node biopsy could be a great alternative.

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Characterising inflammatory mediators in endometriosis

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Background

Endometrial cells in endometriosis are particularly sensitive to oestrogen, which promotes painful inflammation and spurs lesion growth. However, little is known about the bioactive lipids that regulate immune and endometrial cell function. In this study, inflammatory factors were analysed to improve our understanding of the peritoneal microenvironment and its impact on disease development and progression.

Methods

Peritoneal fluid, peritoneal wash and endometrial samples[JA1] were obtained from consenting women with and without endometriosis at laparoscopic surgery (n=61). The washes (20ml sterile saline solution) were taken when there was insufficient peritoneal fluid for aspiration. Assessment of an array of 79 lipid mediators was performed using liquid chromatography tandem mass spectrometry with electrospray ionisation (UPLC/ESI-MS/MS).

Results

The concentration of cyclooxygenase (COX) and lipoxygenase (LOX)-derived lipids were generally lower in women with endometriosis, whilst cytochrome P450 (CYP450) products were higher. Lipid profiles did not significantly change in peritoneal fluid and washes between patient groups. However, there was an apparent decline in 15-LOX metabolites in peritoneal fluid from patients with endometriosis compared with controls.

Conclusions

These findings indicate that there are distinct lipid profiles in endometriosis. Interestingly, endometrial changes in COX, LOX and CYP450 products may have a role in inflammation and pain perception. It is possible that lower 15-LOX in the peritoneal fluid may also help endometriosis tissues evade immune surveillance and cell apoptosis. Lipid signatures therefore warrant further investigation to explore their role in this chronic disease.

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Ovarian steroid cell tumour in a teenager masquerading as polycystic ovary syndrome: A case report and literature review

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Background

Adolescent patients presenting with hyperandrogenic symptoms often receive a diagnosis of polycystic ovary syndrome (PCOS). However, accurate diagnosis is crucial because the symptoms of rare conditions, such as ovarian steroid cell tumour (OSCT), can mimic PCOS.

Methods

Chief complaint, personal and family history, physical, laboratory and imaging examination, diagnosis, treatment, and follow-up of the patient are presented. For literature review, while OSCT and its synonyms, ovarian steroid cell tumour, ovary steroid cell tumour, ovarian steroid cell tumour, ovarian steroid cellular tumour, were used, PCOS and its synonyms, polycystic ovarian syndrome, polycystic ovary syndrome, polycystic ovarian syndromes, polycystic ovary syndromes were involved to the search target. These two topics were searched and joined with AND in Pubmed. Other literature types were excluded except case report using the filter provided by Pubmed. Then we limited the search result using tittle/abstract filter provided by Pubmed to get pre-target case reports. All full text of pre-target papers were read and find out similar case reports which report clinical cases of OSCT-NOS misdiagnosed as PCOS. This search strategy was done by two co-authors independently.

Results

Case summary: An 18-year-old female presented with irregular menstrual cycles, hyperandrogenic symptoms, and obesity. Despite standard treatments for PCOS, symptoms persisted. Exploratory laparoscopic examination revealed an OSCT. Thorough hormonal profiling, imaging, and histopathological analysis confirmed the diagnosis.

Literature review: All OSCT and PCOS with their synonyms were searched in Pubmed on March 1, 2025. After limited the topic to tittle/abstract and then screened manually, only one report was found to present similar OSCT-NOS case with the case we report here.

Conclusions

This case highlights the need for accurate diagnosis, early evaluation, and timely intervention in adolescents with hyperandrogenism to manage rare conditions like OSCT. Adolescent females with hyperandrogenic symptoms are often diagnosed with polycystic ovary syndrome (PCOS). However, the symptoms of rare conditions like ovarian steroid cell tumours can mimic symptoms of PCOS. This case highlights the importance of an accurate diagnosis and a thorough evaluation through hormonal profiling, imaging, and exploratory laparoscopy. If the standard PCOS treatments are unsuccessful,

then alternative diagnoses such as ovarian steroid cell tumour should be considered. Early identification and appropriate management are critical for satisfactory patient outcomes and emphasize the need for heightened awareness of rare conditions that present similarly to PCOS in adolescents.

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Management of ovarian torsion: a call for change towards ovarian conservation

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Background

This audit aimed to evaluate the diagnostic and surgical management of ovarian torsion at University Hospitals of North Midlands (UHNM), focusing on treatment delays, urgency categorisation, and adherence to national recommendations supporting ovarian-conserving surgery. Given observed variability in local practice, we also propose a "Save the Ovary" pathway to support timely diagnosis, improve triage, and increase ovarian salvage rates.

Methods

A retrospective audit was undertaken for all patients with confirmed ovarian torsion between January 2021 and September 2024. Forty-three cases were identified through hospital coding, and data were extracted from electronic and paper records. Quantitative data included timelines of symptom onset, imaging, surgical intervention, and surgical outcomes. Qualitative assessment explored clinical decision-making. Audit standards were derived from national guidance recommending E1 surgical categorisation and laparoscopic detorsion in premenopausal women, regardless of ovarian appearance.

Results

Delays were prevalent: 23.3% of patients experienced over 24 hours' delay before gynaecology referral, and 39.5% underwent surgery more than 72 hours after admission. Imaging delays of over 6 hours occurred in 45.9% of cases. Only 23.3% of all patients (24.1% of premenopausal patients) were appropriately categorised as E1, falling short of national standards. Surgical outcomes included salpingo-oophorectomy in 60.5%, oophorectomy in 7%, and ovarian cystectomy in only 32.6% of cases. Among premenopausal women, 55.2% underwent oophorectomy, despite histology showing torsion without underlying pathology in 16.3%. Ovarian infarction or ischaemia was identified in 27.9%, typically in cases with significant surgical delay.

Conclusions

This audit reveals significant delays and inappropriate urgency categorisation in the management of ovarian torsion at UHNM, contributing to high rates of ovarian removal, particularly among premenopausal women. Despite national recommendations supporting conservative management, adherence remains low. We propose the implementation of a local "Save the Ovary" pathway to promote timely diagnosis, improve triage, and prioritise ovarian-sparing surgery. Targeted staff education and the introduction of local protocols are essential to enhance ovarian salvage and patient outcomes.

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A retrospective magnetic resonance imaging-based review of endometriosis in patients over 50

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Background

The hypoestrogenic state of menopause should lead endometriosis becoming less active. Post-menopausal endometriosis knowledge is relatively scarce compared to information about the disease's pre-menopausal characteristics. This review aims to shed more light on aspects of endometriosis in women over the age of 50, associated gynaecology conditions, and pelvic malignancy.

Methods

We analysed 100 consecutive Magnetic Resonance Imaging (MRI)-confirmed cases in women over the age of 50 between 2019 to 2024. Demographics (e.g. age, body mass index, menopausal status), presenting symptoms, imaging features, management outcomes, and documentation completeness were analysed. We specifically looked at cancer prevalence and surgical planning and outcomes.

Results

Preliminary results show a median age of 54 years. Commonest presenting complaints include post-menopausal bleeding, pelvic pain, and adnexal cysts. In 82% of patients there was no known history of endometriosis. Hormone-replacement therapy did not appear to influence the prevalence of pain, adnexal cysts, or bleeding. 10% of patients had a cancer diagnosis made - endometrial, ovarian, and colorectal in origin. Imaging revealed adenomyosis in 54%, deep infiltrative disease in 36%, and endometriomas in 10%.

Conclusions

The preliminary review results demonstrate a cancer risk of 10% in the over 50s population with endometriosis. Gynaecologists need to be mindful of the importance of considering undiagnosed endometriosis in this cohort of patients. The importance of imaging in the workup, and potential surgical complexity when operating on these patients. Multidisciplinary care is recommended with the hope to reduce the risks of operative complications and improve patient outcomes. Data will be completed, and available for presentation at the time of conference.

<https://esge.covr.be/cmdocumentmanagement/conferencemanager/documents/api/getdocument/14670/cmabstsms/0000199880/8ed38d0045b4855926f009204ab75156169f8744c6c123053fc51ef55657e5fb>

Pain management in outpatient hysteroscopy: a literature review searching for consensus

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Background

Outpatient hysteroscopy is a fundamental procedure in diagnostic and therapeutic gynaecology. While the outpatient setting is becoming more favoured over general anaesthesia due to its numerous benefits, pain remains the leading reason for procedural failure. Currently, there is a lack of sufficient high-quality evidence to recommend the most effective analgesia.

This review aims to evaluate the effectiveness and adverse effects of pharmacological analgesic interventions administered through specific routes in reducing peri-procedure pain, compared to a placebo, no treatment, or other medications.

Methods

We began our literature search following the publication of the last Cochrane review in 2017, covering the period from October 2017 to October 2023. A systematic review was done looking specifically at randomised controlled trials (RCTs) comparing pharmacological interventions with other pharmacological treatments, as well as pharmacological interventions versus placebo or no treatment. Our search adhered to Cochrane's methodological standards and involved a comprehensive range of databases, including the Cochrane Gynaecology and Fertility (CGF) Trials Register, CENTRAL, MEDLINE, Embase, PsycINFO, EBSCO CINAHL, in addition to reference checking. The primary outcome was pain during and after hysteroscopy, while secondary outcomes included procedure failure and adverse events. Studies used visual analogues scales, and we used a standard mean difference (SMD) for all continuous variables to compare outcomes.

Results

Three RCTs were deemed eligible and suitable for analysis, with most showing a low risk of bias. Preliminary results, which were analysed in conjunction with studies from the 2017 Cochrane review, showed that local anaesthetics and opiates had statistically significant lower pain scores. Non-steroidal anti-inflammatory medications failed to show any significant pain relief compared to placebo.

Conclusions

Though some results showed statistical significance, there was no consistent, high-quality evidence to suggest a clinically significant difference in safety or efficacy between the various types of pain relief. New studies have been identified since the last literature search, we aim to include and present these with the current results.

<https://esge.covr.be/cmdocumentmanagement/conferencemanager/documents/api/getdocument/14671/cmabstsms/0000199880/409bf036ee04842b9c02c84510bd2995566ddb5d887420738896b54e4e16454>

A rare congenital urogenital abnormality unmasked by ART failure: a delayed diagnosis of OHVIRA syndrome

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Background

Our objective is to report a rare case of obstructed hemivagina and ipsilateral renal anomaly (OHVIRA) syndrome diagnosed following multiple failed intracytoplasmic sperm injection (ICSI) attempts, and to underscore the importance of thorough uterine evaluation in women with recurrent implantation failure.

Methods

A 24-year-old nulligravid woman was referred to our assisted reproductive technology (ART) unit due to recurrent implantation failure. Menarche had occurred at the age of 12, followed by regular menstrual cycles accompanied by mild to moderate dysmenorrhea. She had a known history of congenital left renal agenesis. The patient had been married for four years and reported chronic dyspareunia. Despite two years of infertility treatment, including two ICSI cycles followed by frozen embryo transfers, no clinical pregnancy was achieved.

Her ovarian reserve parameters were within normal limits as well as the semen analysis. Hysterosalpingography (HSG) was reported as a unicornuate uterus with a blocked and sacculated ipsilateral fallopian tube. On bimanual pelvic examination, a well-defined, fluid-filled mass was palpated along the left lateral vaginal wall. Transvaginal ultrasonography revealed a well-circumscribed, heterogeneous echogenic mass adjacent to the uterine cavity. Pelvic magnetic resonance imaging (MRI) showed uterus didelphys with an obstructed hemivagina and ipsilateral renal agenesis, consistent with OHVIRA syndrome.

Results

Concomitant diagnostic laparoscopy and hysteroscopy were performed. Transvaginal excision of the left longitudinal vaginal septum was carried out, and approximately 150 mL of retained hematocolpos was evacuated. A right-sided pyosalpinx was visualized intraoperatively, and the left fallopian tube appeared hypoplastic. Bilateral salpingectomy was performed. Postoperatively, the patient experienced complete resolution of pelvic pain and dysmenorrhea. A third ICSI cycle was initiated, and a day 5 blastocyst was transferred. The patient achieved a clinical pregnancy of monochorionic monoamniotic twins, who were delivered via caesarean section at 32 weeks of gestation. At the 3-month postpartum follow-up, she reported regular and painless menstruation and remained asymptomatic.

Conclusions

OHVIRA syndrome is a rare congenital müllerian anomaly that may seldomly remain undiagnosed until adulthood due to its subtle presentation. It should be considered in patients presenting with unexplained infertility, dysmenorrhea, dyspareunia, and ipsilateral renal agenesis. Delayed diagnosis may contribute to serious complications, including endometriosis, chronic infection, and

implantation failure. MRI remains the gold standard for diagnosis. Early and definitive surgical correction can alleviate symptoms and significantly improve reproductive outcomes.

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Pregnancy in giant fibroids in a 46 years old followed by Flv-case presentation

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Background

The case of a giant fibroma (3,5 kg) in a 46 years old followed by GnRh analogs and IVF that terminated with pregnancy

Methods

We present the case of a 46 years old female patient, highly anemic (Hb-6,5) with huge fibroma (35/25 cm), reluctant to progestagens or analog of Gn Rh that wanted to preserve her fertility .

Results

We treated the fibroids by myomectomy and then one month of Gn Rh followed by IVF (with donated oocytes) and resulted in a 38 weeks pregnancy with a placental previa and gave birth through C section.

Conclusions

Although it was a high risk case, performing the myomectomy and saving the uterus was the best solution to get a gestation almost through term. We engaged to respect her wish to preserve the fertility even it was a high risk surgery

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A glutamine-induced multifunctional injectable hydrogel for accelerating vaginal wound healing

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Background

In both clinical and research settings, the rapid healing of vaginal injuries after vaginoplasty remains a significant challenge globally. Conventional treatment methods often involve extended recovery periods and increased risk of retrograde infections, causing significant pain and discomfort for patients. To address this issue, an injectable, anti-swelling, stable hydrogel has been developed to facilitate vaginal wound repair.

Methods

First, to confirm the design and characterization of hydrogel, the structure is characterized by scanning electron microscope (SEM), fourier transform infrared spectrometer (FTIR), small angle X-ray scattering (SAXS). Then, rheological tests, fatigue resistance test, mechanical and anti-swelling properties measurements were applied to elucidate the hydrogel properties. In order to evaluate the biocompatibility, we employed elution medium model, investigate the in vitro cytotoxicity of the hydrogel using live/ dead cell staining and cell counting kit-8 (CCK-8) cell viability assay. Meanwhile, to further investigate the in vivo biocompatibility, we implanted the hydrogel into the dorsal skin of rats and collected samples for hematoxylin and eosin (HE) staining and interleukin-6 (IL-6) immunohistochemical staining. Finally, to evaluate the wound healing effect of the hydrogel and molecular mechanisms involved in the healing process in vivo, we established a standardized rat vaginal defect model and captured wound photos followed Hematoxylin and Eosin (H&E) staining, Masson's trichrome staining, Ki-67 immunohistochemical staining, and TGF- β , CD31, vWF immunohistochemical staining.

Results

This 2-hydroxyethyl methacrylate, sodium alginate/Mg²⁺, L-glutamine hydrogel (PHSG-Mg²⁺ hydrogel) has good injectability and can accurately fit the vaginal shape of different patients. By introducing the complexation of sodium alginate and Mg²⁺, a hydrogen bond/coordination bond dual physical cross-linking network structure is constructed, which significantly improves the mechanical properties and anti-swelling ability of the hydrogel, so that the hydrogel could basically maintain its initial shape within 30 days, providing continuous support and protection for vaginal wounds. At the same time, the hydrogel also has excellent biocompatibility and has shown a significant therapeutic effect in promoting wound healing in the rat vaginal wound model by enhancing epithelium growth, accelerating extracellular matrix formation, and promoting vasculature.

Conclusions

Collectively, our findings indicate that PHSG-Mg²⁺ hydrogel provides a new method for achieving satisfactory wound healing and supports the potential use of mechanically robust hydrogel as a drug-free therapy after vaginoplasty.

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The Clinical Correlations between Uterine Fibroids and Lower Urinary Tract Symptoms and Sexual Function

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Background

Lower urinary tract symptoms (LUTS) are commonly linked with pelvic pressure and defecatory symptoms in women with uterine fibroids. The aim of this study is to evaluate the clinical correlations between Uterine fibroids and Lower Urinary Tract Symptoms (LUTS) and Sexual Function after High-intensity Focused Ultrasound (HIFU) therapy.

Methods

Methods: Seventy- five women with symptomatic uterine fibroids and adenomyosis were scheduled for high-intensity focused ultrasound ablation for uterine fibroids. All subjects underwent Magnetic Resonance Imaging of Uterus, LUTS severity and sexual function was assessed by using questionnaires OABSS, UDI-6, IIQ-7, ICIQ-SF, FISl before and three months post HIFU treatment.

Results

Results: Among these 75 patients, 45 of them presented with anterior wall uterine fibroids while 30 of them had not anterior located uterine fibroids. There was a significant improvement in uterine reduction rate ($27.1 \pm 15.2\%$, $P < 0.05$) and fibroid reduction rate ($40.68 \pm 23.85\%$, $P < 0.05$) after 3-month HIFU treatment and symptomatic improvement in genitourinary symptoms with total reduction in OABSS, UDI-6, IIQ-7, ICIQ-SF score postoperatively ($P < 0.05$). The scores of all parameters of FSFI except the satisfaction and pain domain, improved significantly after HIFU therapy ($P < 0.05$). In subgroup OABSS analysis, LUTS severity was correlated with uterine volume and uterine greatest diameter with significant improvement of OABSS scores while the uterine fibroid location had no significant changes in OABSS score after treatment.

Conclusions

Conclusion: Successful ablation and shrinkage of uterine fibroid size alleviates the bothersome LUTS symptoms through reducing in bulk symptoms and also improvement in sexual function. LUTS severity was correlated with uterine volume & uterine greatest diameter but not with the location of uterine fibroids.

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Recommendations for Ergonomic Improvements in Minimally Invasive Gynaecological Surgery Based on Current Literature

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Background

Minimally invasive gynaecological surgery (MIGS) offers significant advantages for patients but poses ergonomic challenges for surgeons, increasing the risk of musculoskeletal disorders (MSDs). The optimization of ergonomics within the operating room is crucial to mitigate these risks, protect the health and well-being of surgical personnel, and ensure the sustained efficiency and quality of surgical care. This review synthesizes current evidence to provide an overview of ergonomic challenges in MIGS and offers concise, clinically useful recommendations for improvement.

Methods

A systematic literature review was conducted using ScienceDirect, PubMed/Medline, and Google Scholar databases to identify relevant studies. The search focused on studies evaluating ergonomic factors and surgeon strain parameters in laparoscopic and robotic gynaecological surgery. Keywords included "laparoscopic," "robotic," "ergonomics," "musculoskeletal," and "gynaecologic." Data extraction and synthesis were performed according to PRISMA guidelines. Both subjective (e.g., questionnaires) and objective (e.g., electromyography, kinematic tracking) research tools used to assess surgical ergonomics were evaluated.

Results

The review highlights a high prevalence of MSDs among MIGS surgeons, with reported rates reaching up to 74%. Key ergonomic risk factors include prolonged static postures, awkward body positions, repetitive movements, and the use of poorly designed instruments. Common MSDs reported by surgeons include neck pain (56-85%), shoulder pain, and low back pain (up to 68%). Contributing factors include instrument design flaws, suboptimal equipment placement, and specific surgical techniques.

Based on the evidence, the following ergonomic recommendations are emphasized:

Intraoperative Breaks: Incorporating even brief breaks during surgery can reduce psychological stress and maintain performance without prolonging operative time.

Surgeon Positioning: Optimizing body positioning, including neck flexion (15°-25°), shoulder abduction (<20°) and internal rotation (<40°), elbow flexion (90°-120°), and wrist positioning (≤15° deviation/flexion), is crucial. Proper foot pedal placement is also important.

Instrument and Equipment Design: Using ergonomically designed instruments with features like angled handles and adjustable grips can reduce strain. Correct placement of monitors to minimize neck flexion is essential.

Training and Education: Structured training programs can improve ergonomic awareness and skills among surgical teams.

Environmental Modifications: Adjusting lighting, temperature, and noise levels in the operating room can enhance comfort and reduce strain.

Robotic surgery offers potential ergonomic advantages but requires specific console setup and attention to bedside assistant ergonomics.

Conclusions

Implementing ergonomic improvements is essential to minimize MSDs and promote surgeon well-being and efficiency in MIGS. This review consolidates evidence-based recommendations for optimizing the surgical environment, instrument use, and surgical technique. Adopting these recommendations can contribute to a safer, more sustainable practice of MIGS.

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Optimising laparoscopic training: the role of visualisation in skill development

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Background

Visualisation is a cognitive technique that involves mentally rehearsing a task or skill, without physical movement. This study aimed to evaluate the effectiveness of visualisation as a training tool in laparoscopic simulator exercise and compare it to traditional repeated physical practice.

Methods

Fifty medical students with no laparoscopic experience, were randomly assigned into two groups. Group 1, "laparoscopic group" (n=25) performed a validated hand-eye coordination laparoscopic exercise using GESEA LASTT model seven times in succession, each lasting two minutes, aiming to place up to 12 coloured rings to metal nails. Group 2, "visualization group" (n=25) performed the exercise physically on attempts 1, 4, and 7, while attempts 2, 3, 5, and 6 were completed using only visualization. Scoring was performed based on the number of placed rings (range 0-12 points). Performance of both groups was compared. Statistical analysis was performed using SPSS software (version 25). Friedman test and Mann-Whitney test were used to compare data within and between groups. A p-value of < 0.05 was considered statistically significant.

Results

Mean scores in the laparoscopic group increased from 2.92 ± 2.14 (1st attempt) to 6.52 ± 3.26 (4th attempt) and 8.24 ± 2.86 (7th attempt). In the visualisation group, scores rose from 2.88 ± 1.72 (1st attempt) to 5.76 ± 2.57 (4th attempt) and 7.44 ± 2.99 (7th attempt). Within-group analysis revealed a statistically significant improvement in performance across the 1st, 4th, and 7th attempts for both the laparoscopic ($p < 0.01$) and the visualisation group ($p < 0.01$), indicating effective skill acquisition in both training approaches. The visualisation group demonstrated performance outcomes comparable to the repeated physical practice group, with no significant difference in the number of pins placed on the 4th and final (7th) attempts ($p = 0.39$). Compared to only the first three repetitions in laparoscopic group (mean scores: 2.92 ± 2.14 , 4.96 ± 2.53 , and 5.52 ± 2.82 , respectively), the visualisation group performed significantly better ($p < 0.05$), suggesting a measurable benefit of mental rehearsal between physical attempts.

Conclusions

Visualisation is an effective complement to physical practice in laparoscopic training. It enables comparable skill acquisition to repeated hands-on training and offers significant advantages over limited physical repetition alone. These findings suggest that the integration of structured visualisation techniques into surgical education curricula might be a time-efficient and resource-conscious approach for developing laparoscopic skills.

Uterocervical Angle and Pain in Office Hysteroscopy

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Background

Office hysteroscopy is gaining increasing relevance in modern gynaecological diagnostics and interventions, offering direct intrauterine visualization in an outpatient setting without the need for general anaesthesia. Despite its minimally invasive nature, pain and discomfort during the procedure remain the main limiting factors, influencing both patient compliance and procedural feasibility. Identifying individual anatomical factors that may predict increased pain perception could contribute to more personalized pre-procedural strategies and patient counselling. This study aimed to evaluate whether the uterocervical angle, as measured by transvaginal ultrasound, correlates with pain perception during diagnostic office hysteroscopy in a homogeneous cohort of nulligravid infertile patients.

Methods

We retrospectively analysed data of 68 nulligravid women with primary infertility using the UTEROMAP protocol, a structured ultrasonographic method for uterine morphometry. We recorded the length of the uterine body (co), cervical length (cx), and total uterine length (u3), and applied the law of cosines to calculate the uterocervical angle (UCA)—the angle enclosed between the uterine corpus and cervix. Following ultrasound, patients underwent diagnostic office hysteroscopy with endometrial biopsy, performed via a 5.5 mm double-flow hysteroscope using a vaginoscopic approach without any form of anaesthesia or analgesia. Room temperature saline (70 mmHg) was used for distension. Discomfort was assessed after the procedure using a 0–10 Visual Analogue Scale (VAS).

Results

The mean patient age was 35.2 years, with a mean BMI of 23.95. The mean UCA was 124.3° (SD $\pm 27.3^\circ$, range: 69.3°–180°), and the mean VAS score was 2.47 (SD ± 1.77 , range: 0–7.2). Shapiro–Wilk tests revealed that VAS scores were not normally distributed ($p < 0.001$), whereas UCA showed borderline normality ($p = 0.057$). Pearson and Spearman correlations showed no significant association between UCA and VAS ($r = 0.028$, $p = 0.062$; both $p > 0.6$). Linear regression analysis confirmed the absence of a significant predictive relationship. Patients were subsequently grouped by UCA into three categories: $<100^\circ$, $100\text{--}140^\circ$, and $>140^\circ$. A Kruskal–Wallis test comparing VAS scores across groups revealed no statistically significant differences ($p = 0.200$), though a trend was observed where both extreme groups ($<100^\circ$ and $>140^\circ$) had slightly higher median pain scores compared to the intermediate group.

Conclusions

Our findings suggest that the uterocervical angle, as an individual anatomical factor, does not significantly influence pain perception during office hysteroscopy. This aligns with data found in literature, which has so far failed to identify consistent, patient-specific predictors of procedural discomfort. While our sample was uniform and clinically relevant, its size remains a limitation.

Further studies with larger cohorts and multifactorial models are warranted to better understand the anatomical and procedural contributors to pain during hysteroscopy.

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Laparoscopic isthmocele repair: A six-case clinical experience

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Background

Isthmocele, also known as a caesarean scar defect or niche, is an increasingly recognized complication of caesarean delivery. While it may be asymptomatic, it often presents with postmenstrual spotting, pelvic pain, dysmenorrhea, or secondary infertility. Laparoscopic repair offers a minimally invasive and effective approach to restore uterine wall integrity and alleviate symptoms in selected patients. In this study, we aimed to report our clinical experience and short-term outcomes of laparoscopic isthmocele repair in a series of symptomatic patients.

Methods

We reviewed six symptomatic patients who underwent laparoscopic isthmocele repair between 2023 and 2025 at our tertiary university hospital. All patients presented with either postmenstrual bleeding or secondary infertility and had a residual myometrial thickness (RMT) of less than 3 mm. A standardized three-port laparoscopic technique was performed by a single surgeon, involving excision of the fibrotic scar tissue and reconstruction of the uterine wall with a double-layer closure using absorbable sutures. Clinical outcomes were evaluated through postoperative follow-up and transvaginal ultrasonography.

Results

The mean age of the patients was 35.7 years, and they had 1 to 3 previous caesarean deliveries (mean: 1.8). Postmenstrual bleeding was the most frequent presenting symptom (n=4), followed by secondary infertility (n=2). No intraoperative or postoperative complications occurred. The mean operative time was 44.8 minutes, and all patients were discharged after one day of hospitalization. Follow-up transvaginal ultrasound demonstrated increased residual myometrial thickness and complete resolution of the niche in all patients.

Conclusions

Laparoscopic isthmocele repair appears to be a safe and effective surgical option for symptomatic patients with thin residual myometrium. In this case series, favourable short-term outcomes were achieved without intraoperative or postoperative complications. These results support the role of laparoscopy in the management of caesarean scar defects and may serve as a basis for further clinical experience and comparative studies. Further follow-up is required to assess long-term reproductive outcomes and radiologic findings.

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Pilot study on feasibility and early outcomes of Robotic Sacrocolpopexy with the Versius® Platform

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Background

Minimally invasive sacrocolpopexy is regarded as the gold standard for Pelvic Organ Prolapse (POP) surgical treatment, with excellent anatomical and functional outcomes, high success rates, and low recurrence risk compared to alternative techniques. We present the first case-series of robotic sacrocolpopexy (RSCP) performed using the Versius Surgical System® (CMR Surgical, Cambridge, UK). This system features independent mobile bedside units and wristed instruments. The surgeon operates from an open console completely controlled by ergonomic handgrips. Our aim is to provide a detailed analysis of RSCP procedures performed using this system, evaluating its feasibility and outcomes.

Methods

After comprehensive preoperative evaluation and adequate counselling on different surgical approaches, 20 patients with symptomatic multicompartmental, ICS POP-Q stage \geq III POP underwent subtotal hysterectomy with salpingectomy/salpingo-oophorectomy and RSCP using the Versius® system from May 2024 to December 2024. The optimal setting of the Versius® platform, perioperative outcomes, and anatomical and functional results were assessed.

Results

The procedures were completed with neither conversion to other surgical approaches nor intra- or post-operative complications. Perioperative data are reported in Table 1. Median estimated blood loss was 20 ml. No system errors or faults of robotic arms were recorded with the chosen three-robotic-arm configuration. Median docking time and console time were 4 and 113 minutes, respectively. Median discharge time was 2 days. Urogynaecological examination at three-months demonstrated statistically significant improvement of prolapse POP-Q stage ($p < 0.001$), and symptoms like vaginal bulging ($p < 0.001$). Patient-reported outcome data showed that all 20 (100%) women had Patient Global Impression of Improvement (PGI-I) scores 1–2.

Table 1: Perioperative data.

All cases	20
Associated surgical procedures, N (%)	20 (100)
Ventral rectopexy, N (%)	0 (0)

Subtotal hysterectomy, N (%)	20 (100)
Total hysterectomy, N (%)	0 (0)
Salpingectomy / Salpingo-oophorectomy, N (%)	20 (100)
Docking time (min), median (range)	4 (2–12)
Console time (min), median (range)	113 (87–133)
Operative time (min), median (range)	174 (146–229)
Laparoscopic adhesiolysis, N (%)	0 (0)
EBL (ml), median (range)	20 (20–100)
Time to discharge (days), median (range)	2 (2–3)
Conversion, N (%)	
Laparoscopy	0 (0)
Laparotomy	0 (0)
Intraoperative complications, N (%)	0 (0)
Post-operative complications, N (%)	0 (0)
VAS score at 24 h, median (range)	2 (1-5)

Conclusions

RSCP using the Versius® System seems feasible and safe for advanced POP treatment. The procedures were completed without complications or conversions, and perioperative outcomes were favourable, including minimal blood loss, superimposable operative times to other systems, and early discharge. Significant anatomical and symptomatic improvements were observed at three months postoperatively, with high levels of patient satisfaction. These findings, although limited, support the use of the Versius® system as a valuable tool in urogynecologic surgery. Further studies with larger cohorts and longer follow-up are warranted to confirm these promising results.

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Endometriosis and adolescence: evaluation of risk factors for endometriosis questioning adult women about their adolescent history

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Background

Endometriosis diagnosis in adolescent women remains a challenge. The aim of the study was to evaluate the presence of risk factors for endometriosis during adolescence according to available literature.

Methods

We conducted a bicentric, prospective, observational case-control study. Patients aged between 20 and 50 years were enrolled, with a diagnosis of endometriosis (cases) or without a diagnosis of the disease (controls). The patients were given a questionnaire investigating the presence of risk factors for the development of endometriosis during adolescence.

Results

A total of 246 patients were enrolled, including 140 women with a diagnosis of endometriosis (cases) and 106 women without endometriosis (controls). The comparison between the two groups revealed in women with endometriosis a significantly higher prevalence of dysmenorrhea (88.6% versus 69.8%, $p<0.001$), periovulatory pain (60.0% versus 29.2%, $p<0.001$), acyclic abdominal pain (17.1% versus 3.8%, $p<0.001$), dyspareunia (38.6% versus 14.2 %, $p<0.001$), gastrointestinal symptoms such as dyschezia (24.3% versus 6.7%, $p<0.001$), constipation (27.9% versus 8.5%, $p<0.001$), vomiting (12.1% versus 2.8%, $p=0.009$) and nausea (32.9% versus 16.0%, $p=0.003$), urinary tract symptoms (25.7% versus 10.4%, $p=0.012$) and migraine (45.0% versus 24.5%, $p=0.001$) during adolescence. Additionally, the intensity of dysmenorrhea (median Visual Analogue Scale VAS 7.5 ± 1.6 versus 6.4 ± 1.7) and periovulatory pain (median VAS 6.4 ± 1.8 versus 5.1 ± 2.2) was greater in the group of cases. Other risk factors more frequently found in women with endometriosis included: family history of the disease (13.6% versus 2.8%, $p=0.003$), early menarche (40.7% versus 27.4%, $p=0.032$), heavy menstrual flow (mean heavy flow days 1.6 ± 0.5 versus 1.2 ± 0.6 , $p<0.001$), and the use of hormonal (60.0% vs 20.8%, $p<0.001$) and anti-inflammatory (70.0% versus 37.7%, $p<0.001$) therapies during adolescence for the control of painful symptoms. Furthermore, the majority of patients with endometriosis reported a negative impact of the aforementioned symptoms on their psychological health (59.3%) and quality of life (55.0%) during adolescence and the 89.3% of them referred that an earlier diagnosis of endometriosis would have improved their quality of life. The median diagnostic delay for endometriosis in our series was 10.9 years.

Conclusions

Our findings support the hypothesis that endometriosis may originate during adolescence. Early recognition and investigation of risk factors in this age group are essential for timely referral to endometriosis centres, reducing diagnostic delay, and improving the quality of life for young women.

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A Giant Mucinous Borderline Tumour in an Adolescent Girl: A Fertility-Preserving Surgical Approach

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Background

Mucinous borderline ovarian tumours are rare in the adolescent population and often present with non-specific symptoms. In young patients, the risk of malignancy must be balanced with the importance of fertility preservation as a surgical goal. This case report presents a 16-year-old patient who underwent surgery for a large pelvic mass, which was subsequently diagnosed histopathologically as a mucinous borderline ovarian tumour.

Methods

The patient presented with chronic pelvic pain. Transabdominal ultrasonography and pelvic MRI revealed a large, complex cystic mass measuring approximately 24 cm in diameter, originating from the left ovary. The mass contained multiple daughter cysts and exhibited a solid-cystic appearance. There was also suspicion of omental infiltration. Tumour markers were as follows: cancer antigen (CA) 125: 33.3 kU/L (reference: 0–35), CA 19-9: 34.09 kU/L (reference: 0–37.1), inhibin A: 24.40 pg/mL, inhibin B: 147.9 pg/mL, alpha-fetoprotein (AFP): <2 µg/L, and lactate dehydrogenase (LDH): 187 U/L. A fertility-preserving laparoscopic cystectomy was planned. Intraoperative frozen-section analysis reported a mucinous tumour with focal atypical proliferation, and conservative surgery was completed. Final histopathological evaluation confirmed a mucinous borderline tumour originating from the left ovary. Cytological examination of peritoneal washings was negative for malignant cells.

Results

No postoperative complications were observed. The patient continues to attend routine follow-ups and has been adequately informed about fertility preservation strategies and the potential for recurrence.

Conclusions

Although large mucinous borderline tumours are rare in adolescents, fertility-sparing surgery can be safely performed with appropriate surgical planning and intraoperative histopathological evaluation. In young patients with borderline ovarian tumours, preservation of ovarian reserve and reproductive potential should be prioritized, and both the patient and their guardians must be adequately informed about potential risks and management options.

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Robotic excision of deep infiltrating endometriosis, evidence showing its efficacy with no recurrence at subsequent look three years later

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Background

Objective

To demonstrate with evidence the long term successful robotic excision of deep infiltrating endometriosis with no recurrence at three years.

Background:

Endometriosis is a chronic inflammatory disease thought to affect 11% of women in the world. When it is refractory to medical management, surgery may be required. Laparoscopy is the preferred approach, but Robotic excision of endometriosis has gained popularity in recent years due to positive results, less pain and complications. In addition, it is also less stressful for the operating surgeon, which can enhance their career longevity.

Methods

Method:

Case review of a case of deep infiltrating endometriosis managed robotically with pictures taken during initial robotic excision and subsequent look at surgery three years later.

Results

Case:

36 year old female had robotic excision of deep infiltrating endometriosis for her symptoms of chronic pelvic pain, dyspareunia, and dyschezia. She had a raised BMI of 47.6. She declined mirena coil. Her surgery was successful and at her follow up at 6, 12 and 24 months, she reported her symptoms had markedly improved.

However, she had heavy menstrual bleeding secondary to endometrial polyp and suspected adenomyosis. She also had fertility wishes.

She was listed for a repeat robotic surgery to check for endometriosis and excise if found and also tubal dye test, three years after her initial surgery. Findings showed no recurrence of endometriosis had occurred as seen in photos. Fallopian tubes were patent, her uterus was adenomyotic and the endometrial poly was removed via hysteroscopy.

She was very pleased to know she had no endometriosis and the robotic excision done previously was effective.

Discussion:

The goal of endometriosis surgery is to excise all visible endometriosis lesions, associated adhesions and restore normal anatomy.

Complete excision of endometriosis can reduce symptoms and also progression of this chronic disease.

Robotic surgery offers better results as the view is superior and also the instruments are accurate. We can see more endometriosis, excise more and obtain better symptom relief for patients as this case demonstrates.

Conclusions

This case demonstrates that robotic excision of deep infiltrating endometriosis was still effective 3 years later with no recurrence. We also are aware that robotic surgery is associated with less complications, hospital stay and blood loss.

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Bilateral Serous Borderline Ovarian Tumour with Pelvic Lymph Node Metastasis in a Young Woman: A Rare Case Report

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Background

Serous borderline ovarian tumours (SBOTs) are neoplasms typically diagnosed in women of reproductive age and are generally associated with a favourable prognosis. However, the presence of extra-ovarian disease, particularly bilateral ovarian involvement and lymph node metastasis, is rare. Herein, we present an unusual case of bilateral SBOT with concurrent nodal metastasis in a 25-year-old woman.

Methods

The patient presented with chronic pelvic pain. Transabdominal ultrasonography revealed a 20 cm complex cystic lesion with papillary projections in the right ovary and an 8 cm semisolid cystic lesion in the left ovary. Pelvic MRI confirmed a 21×20×9 cm papillary complex mass in the right ovary and a 77×52 mm semisolid mass in the left ovary. Laboratory evaluation showed an elevated cancer antigen (CA)- 125 level of 548 U/mL, while CA 19-9 and other tumour markers remained within normal limits.

An exploratory laparotomy was performed with intraoperative frozen section analysis. Intraoperatively, both ovaries were found to harbour lesions consistent with serous borderline tumours. The surgical procedure included left partial oophorectomy, right ovarian cystectomy, bilateral pelvic lymph node dissection, omental sampling, peritoneal biopsies, and peritoneal fluid collection for cytological evaluation.

Results

Final histopathological evaluation confirmed serous borderline tumour in both ovaries. Surface involvement was noted on the left ovary, whereas the right ovary showed no surface involvement. Tumour cells were identified in both ovaries, the peritoneum, and the peritoneal washing fluid. No tumour was detected in the omentum. However, metastatic involvement was present in both right and left pelvic lymph nodes.

Conclusions

This case highlights the importance of comprehensive surgical staging in serous borderline ovarian tumours. In young patients presenting with bilateral ovarian masses, the presence of rare findings such as lymph node metastasis and positive peritoneal cytology may necessitate reconsideration of fertility-sparing strategies and warrants close postoperative surveillance.

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Comparison of the Association with Malignancy in Cases Diagnosed with Endosalpingiosis and Endometriosis: A Retrospective Pathology Series

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Background

This study aims to compare of the association with malignancy in cases diagnosed with endosalpingiosis and endometriosis.

Methods

The study was conducted at a tertiary – single centre. A total of 240 cases were included in the study, in which at least one adnexa was excised along with hysterectomy and ovarian cyst excision was performed for gynaecological or gynaecological-oncological indications between 2015 – 2025 . Data analysis was performed retrospectively using hospital databases. Patients were classified into three groups: Endometriosis (n = 157), endosalpingiosis (n = 63), and both lesions (n = 20). Demographic and histopathological findings were compared between the groups. Data analysis was performed using SPSS. Ethical approval was obtained from our institutional review board.

Results

The mean age was 37.2 in the endometriosis group, 52.1 in the endosalpingiosis group, and 48.95 in the co-existing group ($p < 0.001$). Malignancy was detected in 8.9% (n = 14) of patients with endometriosis, 17.5% (n = 11) with endosalpingiosis, and 20% (n = 4) of those with both lesions ($p = 0.112$). Clear cell carcinoma was the most frequent histological subtype of ovarian cancer %58.3 (n=7), but the distribution of ovarian cancer subtypes did not significantly differ between groups ($p = 0.105$). Similarly, there was no statistically significant difference between the groups regarding the predominance of endometrioid-type uterine malignancies (81.8%, n=9) ($p = 0.497$).

Laparotomy was performed in 51.6% (n = 81) of patients in the endometriosis group and 82.5% (n = 52) in the endosalpingiosis group. The laparotomy rate was significantly higher in patients with endosalpingiosis ($p < 0.001$). In contrast, laparoscopy was performed in 48.4% (n = 76) of patients in the endometriosis group and 14.3% (n = 9) in the endosalpingiosis group, with a significantly higher rate observed in the endometriosis group ($p < 0.001$).

Conclusions

The association with malignancy among the study groups was not found to be statistically significant. The limitations of this study include its retrospective design, single-centre setting, and limited sample size. Nevertheless, the study aims to contribute to the growing awareness of the potential malignancy risk associated with these incidentally detected pathologies.

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Mechanical ileus due to endometriosis: a case report

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Background

Mechanical ileus is a serious gastrointestinal condition caused by obstruction of intestinal contents. While common causes include adhesions, hernias, and tumours, rare cases are linked to **endometriosis**, making diagnosis and management challenging. This case report describes the presentation, diagnostic process, and management of a patient with mechanical ileus secondary to endometriosis, emphasizing the importance of multidisciplinary evaluation.

Methods

A 42-year-old female presented with abdominal distension, constipation, and diffuse abdominal pain. Imaging revealed colonic dilation with a suspected sigmoid obstruction. Laboratory tests and exploratory laparotomy confirmed an **endometriotic lesion causing the obstruction**. Management included surgical resection (Hartmann's procedure) and post-operative gynaecologic evaluation.

Results

The patient underwent segmental resection of the affected bowel, with post-operative improvement. However, persistent symptoms and gynaecologic history suggested endometriosis. **Histopathology confirmed endometriosis as the cause of the obstruction**, leading to further gynaecologic management.

Conclusions

This case highlights **endometriosis as a rare but significant cause of mechanical ileus**. Early recognition, imaging, and a **multidisciplinary approach involving surgery and gynaecology** are crucial for proper diagnosis and treatment.

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Visceral and subcutaneous adipose tissue assessment by magnetic resonance imaging in women with endometriosis: A prospective study

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Background

Evidence gathered from clinical studies indicated that endometriosis is associated with low body mass index (BMI). However, magnetic resonance imaging (MRI) may provide more accurate and reliable adipose tissue characterization and quantification. We investigated the visceral adipose tissue (VAT), subcutaneous adipose tissue (SAT), and VAT index using MRI and their association with clinical and surgical features in women with endometriosis. There are no similar prospective studies in the literature.

Methods

This prospective study included 30 women diagnosed histopathologically with endometriosis who underwent preoperative abdominal MRI as part of surgical preparation between February and November 2024 at Goztepe Prof. Dr. Suleyman Yalcin City Hospital. All patients were operated on by the same surgeon. A control group consisted of 30 patients who underwent abdominal surgery for benign gynaecological reasons. Subcutaneous adipose tissue (SAT) and visceral adipose tissue (VAT) were measured using the preoperative MRI images. The visceral adipose tissue index (VATI) was calculated using the formula $VATI = VAT / (VAT + SAT) \times 100$ with a cut-off value of 0.265. Endometriosis patients were categorized into Group I ($VATI \leq 0.265$, n=15) and Group II ($VATI > 0.265$, n=15). Clinical, demographic, surgical, and laboratory parameters were compared among the groups.

Results

Non-cyclic pain, dyspareunia, dysmenorrhea, dyschezia, and symptom duration were significantly higher in the endometriosis group ($p < 0.001$, $p < 0.01$, $p < 0.05$). Infertility, chronic pelvic pain, cyst enlargement, and use of medication were also significantly associated with endometriosis ($p < 0.001$). AMH and CA-125 levels were significantly higher, while HbA1c was lower in the endometriosis group ($p < 0.001$, $p < 0.01$, $p < 0.05$). A significant positive relationship was found between the SAT value and CA-15-3 ($rS = 0.291$, $p < 0.05$) and fasting insulin ($rS = 0.298$, $p < 0.05$). A significant positive relationship with HOMA-IR ($rS = 0.343$, $p < 0.05$) and triglycerides ($r = 0.386$, $p < 0.01$), while a negative relationship was identified with HDL ($r = -0.411$, $p < 0.01$). For the VAT value, a significant negative relationship was found with CA-125 ($rS = -0.266$, $p < 0.05$) and HDL ($r = -0.284$, $p < 0.05$). Additionally, a moderate positive correlation was observed with CEA ($r = 0.313$, $p < 0.05$), fasting insulin ($rS = 0.345$, $p < 0.01$), HOMA-IR ($rS = 0.396$, $p < 0.01$), triglycerides ($r = 0.462$, $p < 0.001$), HbA1c ($r = 0.326$, $p < 0.05$), and CRP ($rS = 0.3$, $p < 0.05$). A positive correlation was found with fasting glucose ($rS = 0.263$, $p < 0.05$), total cholesterol ($r = 0.256$, $p < 0.05$), and LDL ($r = 0.298$, $p < 0.05$) and a negative relationship was identified with INR ($rS = -0.311$, $p < 0.05$). Group I had higher weight and BMI compared to Group II ($p < 0.05$). No significant

difference was found between groups I and II in terms of anamnesis, surgical parameters, or laboratory values (except monocytes).

Conclusions

No significant association was found between VATI and the presence, severity, stage, or surgical outcomes of endometriosis. These findings suggest a complex interplay between endometriosis, visceral adiposity, and obesity. We need further prospective studies with larger cohorts and long-term follow-up to clarify this relationship.

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Endometrial resection versus dilation and curettage in the management of perimenopausal vaginal bleeding

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Background

Heavy menstrual bleeding is a frequent concern among perimenopausal women, often leading to considerable physical discomfort and diminished quality of life. Identifying effective and safe treatment modalities is critical for this population. This study aims to evaluate the effectiveness and safety of hysteroscopic endometrial resection (ER) compared to dilation and curettage (D&C) in perimenopausal women with heavy menstrual bleeding and no evidence of atypical endometrial histology.

Methods

A prospective study was conducted at the University Hospital of Obstetrics and Gynaecology "Koço Gliozheni" in Tirana. The study included 23 perimenopausal women with abnormal uterine bleeding, all of whom had benign endometrial histology based on prior biopsy. These patients underwent hysteroscopic ER. Outcomes were compared to a control group treated with D&C. Treatment efficacy was evaluated based on resolution of endometrial hyperplasia (as assessed via follow-up hysteroscopy and histopathology), avoidance of hysterectomy, subjective bleeding control, and patient satisfaction. Safety was assessed by monitoring for adverse events.

Results

In the ER group, 91% (n = 21) of patients experienced complete resolution of bleeding. Only one patient (4%) had persistent hyperplasia requiring eventual hysterectomy, while two patients (8%) underwent hysterectomy due to ongoing haemorrhage. In contrast, in the D&C group, only 44% (n = 20) experienced complete symptom resolution. Additionally, 25% (n = 11) required further treatment, and 31% (n = 14) had persistent hyperplasia necessitating hysterectomy. Two patients also underwent hysterectomy due to persistent bleeding.

Conclusions

Hysteroscopic endometrial resection demonstrates superior efficacy and safety compared to D&C in managing perimenopausal bleeding without atypia. It offers a minimally invasive alternative to hysterectomy and may be considered a first-line surgical option in appropriate candidates.

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Minimizing myometrial trauma in reproductive-age women: Cold Scissors in Laparoscopic Intracapsular Myomectomy

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Background

This study aimed to assess the surgical efficacy and healing profile of laparoscopic intracapsular myomectomies performed using the "cold scissors" technique, with emphasis on minimizing myometrial incision. Primary outcomes included measurements of uterine incision length at the beginning and end of surgery, as well as postoperative healing time.

Methods

A prospective observational cohort study was conducted between May 2017 and June 2022, involving patients diagnosed with intramural uterine fibroids categorized under FIGO types 4 to 6. Eligible participants had fibroids ranging from 4 to 10 cm in diameter. Intraoperative evaluation included measuring the uterine incision at the initial dissection phase and again at the end of the procedure. Additional parameters such as intraoperative blood loss, time to recovery, and reproductive outcomes were analysed.

Results

A total of 112 women were enrolled. The mean initial uterine incision length was 3.6 ± 0.6 cm, which decreased to 2.5 ± 0.4 cm by the end of surgery, suggesting minimal myometrial disruption and favourable contractility. Mean estimated blood loss was 115 ± 22.3 ml. The wound healing interval ranged from 30 to 50 days. Notably, 45 spontaneous clinical pregnancies were achieved postoperatively, with 5 resulting in miscarriage. Importantly, there were no reported cases of uterine rupture. Among patients who subsequently underwent caesarean section, no intra-abdominal adhesions were observed during surgical entry.

Conclusions

The "cold scissors" technique for laparoscopic intracapsular myomectomy presents as a safe and effective approach, particularly suitable for reproductive-age women aiming for fertility preservation. The technique allows for precise fibroid excision with minimal incision length and limited thermal damage to surrounding myometrium. This translates into reduced bleeding, shorter recovery times, and encouraging reproductive outcomes. Its application in minimally invasive gynaecologic surgery reinforces the importance of gentle tissue handling in optimizing both surgical and fertility-related results.

[14480/cmabstsms/0000216960/9d8cd5bc16799dd28947dbee740dba0586fae1f79cfea78a284eecde60dc16ab](#)

An individualized rather than standardized approach in hysteroscopic surgery

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Background

Hysteroscopy is widely used for both diagnostic and therapeutic purposes in cases such as endometrial polyps, submucous myomas, intrauterine synechiae, increased endometrial thickness, and inadequate endometrial sampling. Although it is not a routine recommendation, cervical ripening can be performed prior to hysteroscopy, especially in patients with a high risk of cervical stenosis. Medical treatment may be used to prevent new polyp formation rather than to treat endometrial polyps. Available data on the effect of progesterone use, especially in the postoperative period, on recurrence rates and the endometrial healing process are limited and contradictory.

Methods

In this retrospective study, medical records of patients who underwent diagnostic and/or operative hysteroscopy at Bursa City Hospital between July 17, 2019 and December 22, 2022 were evaluated following local ethics committee approval (Approval number: 2025-9/14). We recorded the demographic characteristics of the patients, their initial complaints, whether they received preoperative misoprostol, and any postoperative use of oral progesterone or levonorgestrel-releasing intrauterine devices. Additionally, we noted any recurrences during follow-up examinations.

Results

This retrospective study included 1004 patients who underwent hysteroscopic surgery. The mean age of the study participants was 44.61 ± 10.33 years (min: 19 years - max: 84 years). 26.59% of the patients were ≥ 50 years old. Among the indications for hysteroscopic surgery, the rates of heavy menstrual bleeding, postmenopausal bleeding, and intermenstrual bleeding were 21.1%, 13.2%, and 6.3%, respectively, while asymptomatic endometrial polyps detected by ultrasonography account for 12.9% of the study population. In patients with unfavourable cervix, operative hysteroscopy was performed under general anaesthesia following preoperative administration of 400µg misoprostol (25.7% [258/1004]), and if required, the cervical canal was visualized with office hysteroscopy. Then the procedure was completed with operative hysteroscopy. Hysteroscopic polypectomy was the most frequently performed hysteroscopic procedure, with a rate of 66.33%. The overall rate of postoperative progestin prescription was 11.35%, and 5.8% of patients received a levonorgestrel-releasing intrauterine device after surgery. The recurrence rate of endometrial pathology was 5.18%, while the recorded complication rate was 0.2%, which is less than the current rate. The recovery rate following hysteroscopic intervention was determined to be 84.1%, while the hysterectomy rate with benign and malignant indications was 3.69%.

Conclusions

While it is not possible to draw a definitive conclusion about the effectiveness of misoprostol due to low complication rates and insufficient surgical records, our clinical observations suggest that its use can facilitate surgery in selected cases. In our clinical practice, we recommend progestin therapy after hysteroscopic surgery, particularly for patients experiencing heavy menstrual bleeding. In this

retrospective analysis, the groups receiving postoperative progestin and those not receiving it were not comparable in terms of recurrence rates. Therefore, large-scale, prospective randomized controlled trials are needed to properly assess the effectiveness of these treatment methods.

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Needle-Free Laparoscopic Transabdominal Rescue Cerclage in Second-Trimester Pregnancy After Cervical Conization

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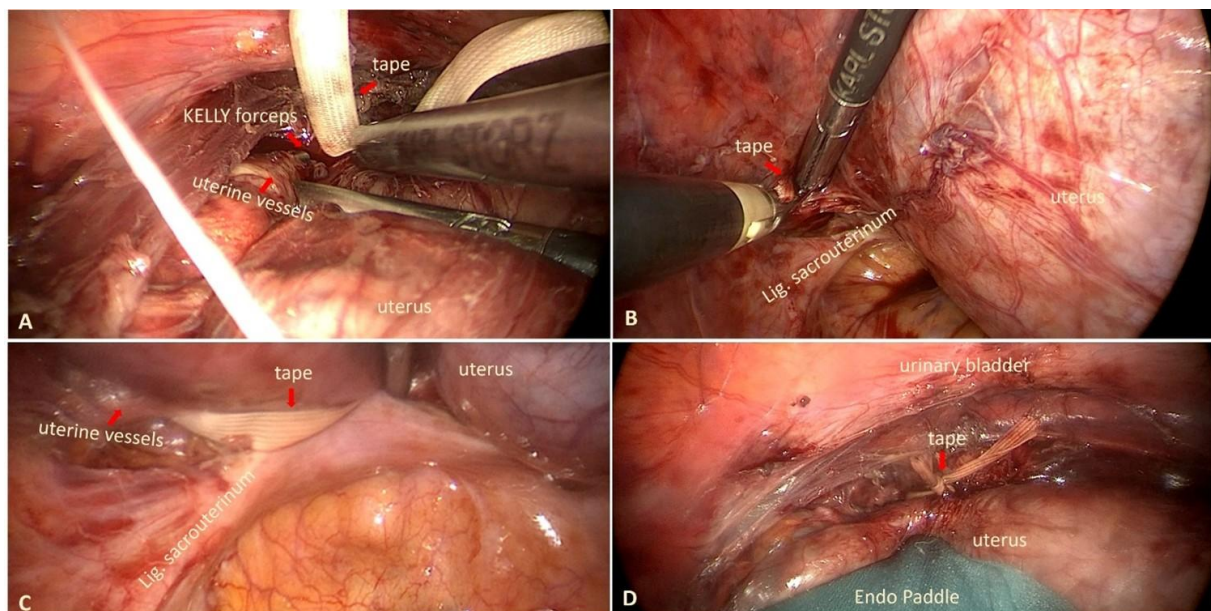
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Background

Advanced cervical shortening in the second trimester carries a high risk of late miscarriage and premature birth. If transvaginal cerclage fails or is no longer anatomically feasible, transabdominal cerclage is the final option. This report describes the technique, feasibility, safety and obstetric outcomes of laparoscopic transabdominal cerclage (LTC) using two case studies.

Methods

LTC was performed on two patients (one at 13 + 0 weeks and one at 15 + 5 weeks of gestation) with cervical insufficiency after conisation or re-conisation, a prior vaginal cerclage had failed due to the fact that the cervix was no longer visible. Following meticulous dissection and identification of the uterine vessels, a non-absorbable tape was passed needle-free around the uterine isthmus through the avascular window between the ascending and descending branches of each uterine artery, and then securely tied (see figure 1). The duration of the procedure, blood loss, and any perioperative or postoperative complications were recorded, as was the course of the pregnancy.



Results

The respective durations of surgery were 93 and 134 minutes; the estimated blood loss was less than 50 ml in both cases. There were no perioperative or postoperative complications. Both pregnancies subsequently progressed without any significant events and with normal foetal development.

Case 1: spontaneous premature rupture of the membranes and secondary caesarean section at 35 + 4 weeks of gestation; birth weight 2786 g, Apgar score 8/9/10 and umbilical artery pH 7.36.

Case 2: primary caesarean section at 39+5 weeks of gestation; birth weight 4,160 g, Apgar score 5/9/10, umbilical artery pH 7.20.

Conclusions

LTC represents a technically feasible, safe and effective treatment option until the early second trimester for patients in whom transvaginal cerclage is not possible due to anatomical conditions or has been unsuccessful. The current findings demonstrate that LTC has the capacity to prolong pregnancy and enhance neonatal outcomes without increasing the risk of perioperative complications [1-4].

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The role of Hysteroscopy in the study of Heavy Menstrual Bleeding (HMB). Our results

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Background

Heavy Menstrual bleeding (HMB) is a common and undervalued gynaecological complaint that affects the quality of life of many women worldwide. Its high prevalence gives it a great social, health and economic impact. Therefore, accurate diagnosis and appropriate treatment are of great importance. The aim of this study is to describe the ultrasound, hysteroscopic and histopathological findings in women with heavy menstrual bleeding who underwent a diagnostic hysteroscopy at our hospital in 2024.

Methods

A descriptive study has been performed in our centre evaluating the diagnostic hysteroscopies in patients with heavy menstrual bleeding from January to December 2024. Transvaginal ultrasound findings were first reviewed to subsequently evaluate the hysteroscopic and histopathological results, separately.

Results

A total of 226 patients were reviewed. The patient's mean age was 44'8 years (range 23-58). Endometrial polyps were the most common ultrasound finding, observed in up to 36% of women, followed by fibroids in 27%. An ultrasound without alterations was found in 23% of women. Thickened endometrium was observed in 13% of patients. In 1% of cases, ultrasound was inconclusive in differentiating between a polyp and a fibroid.

Regarding hysteroscopic findings, endometrial polyps were observed in 36% of patients, while a normal functional endometrium was identified in 25%. Fibroids were diagnosed in 46 patients (20%) and a polypoid endometrium in 10%. Less frequent findings included: hyperplastic endometrium in 5%, signs of endometritis in 1%, and atrophic endometrium in 1% of patients. Atypical hysteroscopic features were observed in two patients (1%) and there was only one case with a hysteroscopic suspicion of endometrial cancer.

Focusing on histopathological findings, 43% of patients were diagnosed with functional endometrium, while endometrial polyps and fibroids were confirmed in 37% and 11% of cases, respectively. Less frequent diagnoses included endometrial hyperplasia without atypia (5%), atrophic endometrium (2%) and hyperplasia with atypia (1%). Endometrial cancer was confirmed in 2 patients, representing 1% of the total sample.

It is noteworthy that while hysteroscopic suspicion of fibroid was reported in 20% of patients, histopathological confirmation was obtained in only 8%. This discrepancy is mainly due to the fact that, in most cases, the biopsy was taken from the endometrium and not directly from the fibroid.

Conclusions

Our results indicate that approximately one-third of the patients were diagnosed with polyps. Another third presented functional conditions, and the remaining third other findings. Endometrial cancer was detected in 1% of the sample (both nulligravidas with BMI of 24 and 52) and atypical hyperplasia in another 1% (previous caesarean section and BMI of 33). These results demonstrate that a multidisciplinary approach enables clinicians to correctly identify and treat the underlying causes of HMB.

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Asymptomatic Endometrial Thickening in Postmenopausal Women

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Background

Asymptomatic endometrial thickening is defined as an endometrial thickness >5mm discovered in an asymptomatic postmenopausal women by ultrasound. This finding represents a clinical management dilemma and constitutes a frequent reason for referral to a gynaecologist.

An asymptomatic woman with an endometrial thickness >11mm and/or other findings on ultrasound has a higher risk of endometrial cancer and should have an endometrial sampling. Hysteroscopy should be considered if the sampling is insufficient for further investigations.

The aim of this study is to describe the ultrasound, hysteroscopic and histopathological findings in postmenopausal women with asymptomatic endometrial thickening who underwent a diagnostic hysteroscopy at our hospital in 2024.

Methods

All hysteroscopies performed in our hospital from January to December 2024 have been reviewed and we have selected postmenopausal women with asymptomatic endometrial thickening. Transvaginal ultrasound findings were firstly reviewed and the patients were categorized into two groups based on endometrial thickness and to subsequently evaluate the hysteroscopic and histopathological results.

Results

A total of 152 patients were reviewed. The women's mean age was 66.1 years (range 47-87). 75% of the patients presented with an endometrial thickness ranging between 5-10 millimetres, while 25% of the patients had an endometrial thickness greater than or equal to 11 millimetres.

Endometrial polyps were the most frequent hysteroscopy finding present in 115 patients (75%) while atrophic endometrium was seen in a total of 20 women (13%).

Atrophic-cystic endometrium was suspected in 8 patients (5%). More infrequent lesions were: Endometrial cancer, proliferative endometrium, hyperplastic endometrium, submucous fibroids, secretory endometrium, endometritis and synechiae, all of them with a 1% representation respectively.

When a histopathological exam was performed, endometrial polyps were found in up to 73% of women. Atrophic endometrium was the next most frequent finding, representing 15% of the results. Far less frequent were atrophic-cystic endometrium (5%), fibroids (2%), normal functional endometrium (1%) and endometritis (1%).

Atypical hyperplasia was diagnosed in only one patient, whereas three patients were diagnosed with endometrial cancer.

Of the patients diagnosed with cancer, only one had an endometrial thickness >11mm, while two of them had an endometrial thickness <11 mm. Two of them were nulligravid, while the third one had

had three full-term pregnancies. Only one of them had a body mass index in the obesity range. Regarding cancer stage, two patients were diagnosed at an early stage, while one presented with advanced-stage disease with metastasis.

Conclusions

Hysteroscopy is an effective endoscopic technique for evaluating endometrial thickening. The ability to perform targeted biopsies under direct visualization is particularly useful for achieving a diagnosis and, most importantly, for ruling out malignancy.

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Evolution of Laparoscopic Hysterectomy Practice in gynaecology departments

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Background

Laparoscopic hysterectomy (LH) has become an increasingly preferred approach for benign gynaecologic pathologies, offering benefits such as reduced postoperative pain and faster recovery. Our study aimed to describe the practice of laparoscopic hysterectomy in the departments of gynaecology at the university hospital centres (CHUs) of Mongi Slim, La Marsa, and Aziza Othmana, Tunisia.

Methods

This is a retrospective descriptive bicentric study over a 10-year period, from January 1, 2013, to December 31, 2022 conducted at the university hospital centres (CHUs) of Mongi Slim, La Marsa, and Aziza Othmana, Tunisia.

Results

We included a total of 556 hysterectomy cases: 295 cases were performed at Aziza Othmana Hospital and 261 cases were performed at Mongi Slim Hospital.

The Abdominal approach (n=322; 57.9%), laparoscopic approach (n=170; 30.6%), vaginal approach (n=64; 11.5%). Laparoscopic hysterectomy increased over time, from 1.5% of procedures in 2013 to 37.8% in 2022.

Starting from 2021, laparoscopy became the most commonly used surgical route, accounting for 36.1% compared to 32.6% for the abdominal approach. Intraoperative complications were observed in 7.4% of cases, the most frequent being haemorrhagic complications (3.8%), followed by bladder injuries (2.7%), digestive and ureteral injuries (0.5% each), and finally vaginal tears (0.2%). The median operative time was 120 minutes (IQR = [90–170]), with a range from 20 to 400 minutes.

No significant difference in the incidence of early postoperative complications was observed based on the surgical approach (laparotomy: p=0.435, vaginal route: p=1, laparoscopy: p=0.249).

Conclusions

Laparoscopic hysterectomy has significantly increased over the past decade, becoming the most common surgical approach since 2021. Despite a longer operative learning curve, it showed a comparable rate of early postoperative complications to other approaches. These findings support the continued adoption of laparoscopy as a safe and effective technique in gynaecologic surgery.

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The role of hysteroscopy in detecting postmenopausal endometrial pathology

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Background

Endometrial cancer is one of the most frequently diagnosed gynaecologic neoplasms, with a growing global incidence worldwide. While advanced-stage cases are associated with poor prognosis, early detection significantly enhances the possibility of favourable outcomes.

This case emphasizes the role of hysteroscopy in identifying women in whom postmenopausal bleeding may be caused by an endometrial cancer allowing the possibility of getting a targeted biopsy which improves, not only the diagnosis but the prognosis in the long term.

Methods

A 75-year-old patient visited our hospital referral from primary care physician due to an episode of postmenopausal bleeding.

A complete gynaecological exam was performed. Transvaginal ultrasound identified a linear endometrium, with a 13 milometers fundal submucosal fibroid and a 17 millimetres subserosal fibroid, with normal ovaries and fallopian tubes. An attempt to perform an endometrial biopsy was made but it was unsuccessful due to cervical stenosis so a diagnostic hysteroscopy was requested.

During hysteroscopy, the endometrial cavity was irregular, primarily affected by a submucosal fibroid that extended to the left uterine margin and without abnormal vascularization. The endometrium, adjacent to and overlying part of the fibroid, had a coralliform appearance with atypical vascularization, suggestive of endometrial cancer. The rest of the endometrial cavity exhibited atrophic-cystic changes. A targeted biopsy of the suspicious lesion was performed and sent for priority histopathological examination.

Results

Histopathological exam confirmed high-grade serous carcinoma, with no loss of DNA repair protein expression, suggesting a low probability of microsatellite instability. A p53 mutated pattern and the POLE mutation testing was negative. Further image studies included a magnetic resonance, which demonstrated less than 50% myometrial invasion (IA stage); and a computed tomography, with no evidence of distant metastasis. Based on the diagnosis, a total hysterectomy with bilateral salpingo-oophorectomy, omentectomy, bilateral pelvic sentinel lymph node biopsy and para-aortic lymphadenectomy via laparoscopy was scheduled.

Conclusions

Transvaginal ultrasound has a high negative predictive value, but relatively low specificity, which means additional tests are needed to detect endometrial malignancy. Hysteroscopy plays a critical role in detecting malignant intrauterine pathology in postmenopausal women with unexplained bleeding. This case highlights the importance of hysteroscopy as a diagnostic tool, especially in time-dependent diseases. The possibility of direct visualization enabled the identification of an atypical

intracavitary lesion, leading to an early histopathological confirmation of a high-grade serous carcinoma.

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Our clinic's experience with laparoscopic myomectomy in the last 10 years: an analysis of 149 patients

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Background

Uterine fibroids are one of the most common benign gynaecologic tumours in women of reproductive age and may cause various clinical complaints such as menorrhagia, pelvic pain, infertility and recurrent pregnancy loss. As an alternative to traditional laparotomy, laparoscopic myomectomy offers advantages such as reduced postoperative pain and shorter hospital stay due to its minimally invasive features.

Methods

In this retrospective study, 149 laparoscopic myomectomy cases performed in our clinic over the past 10 years were analysed according to age, hospital stay, presenting complaints, number - size and FIGO (International Federation of Gynaecology and Obstetrics) classification of fibroids, intraoperative complications, conversion to laparotomy, postoperative haemoglobin loss, and postoperative analgesic requirement.

Results

Laparoscopic myomectomy was performed mostly in patients aged 41-45 years (n=46, 32.2%). The average hospital stay is 2 days. The most common admission complaint was abnormal uterine bleeding, menorrhagia or irregular menstruation with 42 patients (28.2%), followed by female infertility (n=37, 24.9%), pelvic pain (n=35, 23.5%) and abdominal mass (n=6, 4.0%). A single fibroid was removed in 70.4% of patients (n=105) while two fibroids were removed in 18.8% of patients (n=28) and 10.7% of patients (n=16) had three fibroids. The most commonly (37.6%) removed fibroids are between 2.5-5.0 cm while the largest fibroid had a size of 11cm. 38.6% of fibroids were FIGO type 3-4, 45.0% type 5-6, 14.0% type 7 and 4 fibroids were parasitic fibroids. Three of these parasitic fibroids were found on the broad ligaments and one was adherent to the intestine. The only intraoperative complication occurred during the resection of this intestinal parasitic fibroid, involving bleeding from the intestinal mesothelium. No surgery was converted from laparoscopy to laparotomy. Most patients (n=43, 28.9%) had a decrease in haemoglobin levels of 0.6-1.0 g/dL while 9 patients (6.0%) had a loss of >2.5 g/dL. On the first postoperative day, all laparoscopic myomectomy patients receive Diclofenac Sodium 75 mg intramuscular (IM) every 8 hours. On the second postoperative day, we reduce the dose to Diclofenac Sodium 75 mg IM once a day. If the patient still complains of pain despite our routine management, Paracetamol 10 mg/ml intravenous (IV), Dexketoprofen Trometamol 50 mg IV or Pethidine Hydrochloride 100mg/2ml IV are used additionally. 29.5% of patients (n=44) received additional Paracetamol, 19.5% of patients (n=29) Dexketoprofen Trometamol and 10.7% of patients (n=16) Pethidine Hydrochloride in the postoperative period.

Conclusions

Laparoscopic myomectomy is a safe surgical method for the management of uterine fibroids. Minimal intraoperative complications, no conversion to laparotomy, low blood loss, early discharge and the relatively low need for additional postoperative analgesia in our clinical experience support the laparoscopic myomectomy technique.

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Postmenopausal Bleeding: Ultrasound, Hysteroscopic and Histopathological Findings.

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Background

Postmenopausal bleeding is a common gynaecological symptom rising its incidence due to the increase in life expectancy, being one of the main objectives in these patients to rule out endometrial cancer.

Hysteroscopy, with its "see and treat" potential, allows not only the visual assessment of the uterine cavity but the possibility to obtain targeted biopsies which improves the diagnostic accuracy.

The aim of this study is to describe the ultrasound, hysteroscopic and histopathological findings in women with postmenopausal bleeding who underwent a diagnostic hysteroscopy at our hospital in 2024.

Methods

A descriptive study has been performed in our centre evaluating the diagnostic hysteroscopies in patients presenting with postmenopausal bleeding from January to December 2024.

Transvaginal ultrasound findings were firstly reviewed to subsequently evaluate the hysteroscopic and histopathological results.

Results

A total of 155 patients were reviewed. The mean age was 62,5 years (range 46-96).

The most frequent ultrasound findings were endometrial polyps in up to 47% of women, followed by endometrial thickening in 33%. Much more infrequent was the ultrasound finding of a linear endometrium (6%), fibroids (5%) or endocervical polyp (4%). In up to 5% of patients, malignant pathology was suspected by ultrasound.

From the total of 155 patients only 147 hysteroscopies were performed as 8 patients did not show up. Endometrial polyps were the most frequent hysteroscopy finding (45%) while atrophic endometrium was seen in 28% of women. Endometrial cancer and proliferative endometrium were suspected in 8% and 9% of women, respectively. More infrequent lesions were: atrophic-cystic endometrium (5%), hyperplastic endometrium (2%), submucous fibroids (2%) and endocervical polyps (1%).

When a histopathological exam was performed, endometrial polyps were found in 46% women while endometrial atrophy was diagnosed in 29% of our patients, followed by 10 cases (7%) of endometrial cancer. Among the patients diagnosed with endometrial cancer, only one was nulligravid, while the others had had full-term pregnancies. Regarding body mass index (BMI), seven out of ten had BMI values in the obesity range, two were overweight, and just one had a normal BMI. Far less frequent are proliferative endometrium (4%), atrophic-cystic endometrium (4%), hyperplastic endometrium (4%), endocervical polyps (4%) and submucous fibroids (2%).

We have only had one case in which we suspected an endometrial lesion and the histopathological exam yielded a result of cervical cancer.

Conclusions

This review emphasizes the value of hysteroscopy as a fundamental diagnostic tool for evaluating postmenopausal bleeding, providing direct visual access allowing targeted tissue samplings. This enables the identification of atypical features that could point to a malignancy diagnosis.

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Adenocarcinoma with Negative Screening Cytology: Implications for Early Diagnosis and Comprehensive Evaluation

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Background

Cervical cancer remains a significant global health challenge and is one of the most common malignancies affecting women, particularly in regions with limited screening and vaccination coverage. This disease is strongly linked to persistent infection with high-risk human papillomavirus strains and its early diagnosis plays a crucial role in improving its outcomes. Our objective is to highlight the importance of maintaining a high index of suspicion for cervical cancer and to illustrate the need for a deep evaluation when clinical symptoms persist.

Methods

A 48-year-old patient, with normal screening cytologies, attended the hospital complaining of persistent menorrhagia for the past five months. Physical examination was within normal limits, but the transvaginal ultrasound revealed a 3 cm intracavitary lesion. Therefore, at that moment, an endometrial biopsy was taken and a hysteroscopy was scheduled. Before the hysteroscopy, the results of the biopsy were checked: not conclusive. Starting the hysteroscopy, an irregular endocervical canal with diffuse bleeding was observed. However, the uterine cavity showed a secretory endometrium without any alterations. During the procedure, both biopsies were taken (from cavity and from endocervix). Then, a marked bleeding started. To achieve haemostasis, the administration of intravenous tranexamic acid and the placement of a Foley catheter (4cc balloon inflation) were needed. Finally, the patient remained under observation in the emergency department and was discharged afterwards.

Results

Pathological analysis revealed a secretory phase endometrium, whereas the endocervical sample was suggestive of adenocarcinoma. Immunohistochemical profiling demonstrated p16 positivity, a Ki67 index of 20–25%, and a wild-type p53 pattern. Subsequently, cytological review, HPV testing, computed tomography and magnetic resonance imaging were performed. A 46 mm cervical mass corresponding to stage IIA disease was identified. No alterations in cytology or HPV were seen, neither evidence of distant metastasis. Afterwards, the patient underwent a retroperitoneal para-aortic lymphadenectomy. Final results showed no evidence of carcinoma infiltration and immunohistochemical studies turned negative. Currently, the patient is under close follow-up by oncology and radiotherapy services.

Conclusions

This case reinforces the premise that a normal screening cytology does not entirely exclude the possibility of cervical malignancy. The unexpected detection of adenocarcinoma needs a multidisciplinary approach when abnormal uterine bleeding persists. Evaluation through imaging, hysteroscopic assessment and detailed histopathological examination is essential for early diagnosis and treatment, improving patient outcomes in the long term.

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Long-Retained Intrauterine Device (IUD): Unexpected Hysteroscopic Findings

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Background

Intrauterine devices (IUDs) are among the most widely used contraceptive methods worldwide, providing effective long-term birth control for millions of women. While IUDs can remain inside the uterine cavity for extended periods of time without requiring replacement, the use beyond the recommended time may lead to various complications. This clinical case highlights the significance of hysteroscopy as a diagnostic tool for identifying intracavitary pathology associated with retained IUDs.

Methods

A postmenopausal woman visited the clinic with an intrauterine device for its removal. She was asymptomatic and unable to recall the exact insertion date, or the type of IUD used. Upon clinical examination, no IUD strings were visible in the vagina. A transvaginal ultrasound was performed, revealing two findings: an image suggestive of a retained IUD next to the left uterine horn and an occupied endometrial cavity by a hyperechoic punctate pattern, suggestive of pyometra or mucometra. Due to these findings, a hysteroscopy evaluation was requested and prophylactic antibiotic therapy before the procedure was prescribed.

Results

Diagnostic hysteroscopy was performed, confirming the presence of a retained IUD which was found split in two. The metallic part that corresponded to the threads was closer to the endocervical canal and the plastic part corresponding to the arms and stem was found at the uterine fundus. Both parts were successfully removed. During the procedure, the endometrial cavity was filled with purulent material that was collected. After a complete review of the endometrium, targeted biopsies were taken. Both specimens were sent for microbiological and histopathological analysis.

The results revealed an atrophic endometrium with histological evidence of acute and chronic inflammation. It was also observed under the microscope a colonization by *Staphylococcus aureus*. Sexually transmitted infections were excluded by a PCR test.

Doxycycline is prescribed following the antibiogram recommendations and a control appointment is scheduled.

Conclusions

Retained IUDs may be associated with various clinical conditions, including endometritis and abnormal uterine bleeding. Hysteroscopy serves as a highly effective diagnostic tool, allowing direct visualization of intracavitary abnormalities and enabling the guidance of endometrial biopsies for further pathological assessment. This case highlights the importance of hysteroscopic evaluation in diagnosing and managing intracavitary pathology, reinforcing its role in improving clinical outcomes in patients with prolonged IUD retention.

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Single-Step In-Office Hysteroscopic Removal of Submucous Fibroids Larger Than 4 cm Without Anaesthesia

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Background

Submucous fibroids are approximately 15 % of all uterine fibroids and may cause irregular bleeding, pelvic pain, and infertility. Hysteroscopic myomectomy (HM) is a safe and effective technique to treat large fibroids but may require a two - step procedure. In- office hysteroscopic myomectomy poses a challenge of incomplete resection of up to 36.7 % for fibroid size of > 3 cm, patient discomfort, cervical stenosis in postmenopausal women and requires surgical expertise. With the advancement in the hysteroscopic instrumentation and technology, the limits of in- office hysteroscopic procedures are expanding. In this study, we aim to demonstrate the feasibility of a single step in-office hysteroscopic myomectomy of sub-mucous fibroids larger than 4 cm size without anaesthesia.

Methods

In-office hysteroscopic myomectomy was performed in 9 women with FIGO type 0 and type 1 submucous fibroid of size 4 cm and above. They presented with menorrhagia and dysmenorrhoea. One woman presented with infertility. All procedures were performed by a single surgeon in a private hospital, in-office setting without anaesthesia.

In-office hysteroscopic myomectomy was performed using a 16 Fr mini-resectoscope or hysteroscopic tissue removal system, using normal saline and intrauterine pressure were maintained using a pressure pump. In most of the cases, we found that the cervical os was not stenosed and provided easy access of the uterine cavity. We targetted the base of the fibroid, by enucleation technique or cutting the base with bipolar energy. The fibroid was removed it in toto. Preoperative ultrasound fibroid mapping was performed in all cases. No preoperative hormonal treatment was given to these women. The primary outcome measured was the completion of the procedure in a single step. The secondary outcome measured were patient satisfaction, complication rate, challenges faced during in-office hysteroscopic myomectomy and the need for a second procedure.

Results

In eight women, the procedure was completed in a single step. One woman required a second step. The mean age was 44 years. The mean procedure time was 22 min. Six women had a fibroid size of 5 - 6 cm. Three of the fibroids were in the lower uterine segment. The mean visual analogue pain score reported was 3. Eight women were very satisfied with the procedure, one woman was dissatisfied and complained of post-operative pain, and she was treated with analgesics. The median follow-up was 6 months - 2 years. All the women are symptom-free.

Conclusions

In office hysteroscopic myomectomy is feasible in a single step. The technique of targeting the base of the fibroid in select cases facilitates a complete enucleation reducing the procedure time and complications associated with myomectomy in large fibroids.

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A case of disseminated peritoneal leiomyomatosis

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Background

Disseminated intraperitoneal leiomyomatosis is a rare benign condition characterised by several solid peritoneal smooth muscle nodules and fibroids that proliferate along the abdominopelvic cavity . It usually affects women in their reproductive age . Although typically benign, it may have features similar to malignant tumours and thus represents a diagnostic challenge . Diagnostic imaging includes CT and magnetic resonance imaging . It may be related to hormonal influence and has been linked to myoma morcellation during laparoscopic myomectomy.

Methods

We present this rare case of a 37 year old lady who had a laparoscopic myomectomy 8 years ago. she represented to the gynaecology clinic with abdominal bloating, abdominal distention and pressure on the bladder secondary to a large mass. she had a palpable 22-week size uterine mass above the umbilicus on examination. MRI was done that showed disseminated peritoneal leiomyomatosis but malignancy could not be excluded. As she completed her family she was counselled on total abdominal hysterectomy and bilateral salpingo ophorectomy. Intra operatively, a large fibroid was removed around 25 cm attached to the omentum and multiple small fibroids attached along the peritoneal surfaces. histopathology results confirmed benign leiomyomas.

Results

As a very rare disease, disseminated intraperitoneal leiomyomatosis represent a diagnostic challenge .

Conclusions

Due to the low risk of malignancy MRI is recommended with gynae oncology input surgical input .

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Introducing a New Application of the HUGO™ RAS System: ICG Fluorescence-Guided Sentinel Lymph Node Biopsy in Endometrial Cancer – A Case Series

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Background

Minimally invasive surgery is the preferred approach for early-stage endometrial cancer (EC) staging, with robotic-assisted surgery (RAS) increasingly adopted due to its advantages for both patients and surgeons.

The aim of the study is to report the first cases of surgical staging for apparently early-stage endometrial cancer performed using the HUGO™ RAS system with indocyanine green (ICG) fluorescence imaging for sentinel lymph node (SLN) mapping.

Methods

We prospectively recorded demographic, clinical, intra- and postoperative data of all consecutive women who underwent surgical staging for apparently early-stage endometrial cancer, including total hysterectomy, bilateral adnexectomy, and SLN biopsy, with the Hugo RAS system. Surgical technique was standardized across all cases. A four-robotic-arm configuration was used following the "compact bridge" setting. A fifth 5-mm trocar was placed at palmer's point, for the bedside's assistant use. A uterine manipulator was used in one case, as part of an ongoing randomized trial. One mL of indocyanine green dye (2.5 mg/mL) was injected deeply and superficially at 3 and 9 o'clock in the cervix before robotic docking.

Results

Twenty endometrial cancer patients were treated between January and March 2025 at Fondazione Policlinico Universitario Agostino Gemelli IRCCS. Median age was 56 years (45-79), and the average body mass index was 25 (21-30). SLN biopsy was performed on all patients: 19 patients had bilateral successful detection, one patient had unilateral detection and underwent systematic pelvic lymphadenectomy on the unmapped side. Median operative time was 137 (range 113-228) minutes, and the median docking time was 5 (range 5-12) minutes. None of the surgical procedures required conversion to laparoscopic or open surgery, and no intraoperative complications were recorded. Median postoperative stay was 2 days (range 1-2). One early postoperative complication was recorded, specifically a urinary tract infection treated with oral antibiotics (Clavien-Dindo Grade I).

Conclusions

This case series suggests the feasibility of SLN mapping with ICG using the HUGO™ RAS system in EC staging. Our experience demonstrates that this system provides effective visualization of lymphatic channels, enabling SLN identification and dissection. HUGO™ RAS system, including its flexible

docking configurations and the integration of the Rubina® lens system, proved surgical precision and workflow efficiency. The findings from this case support the feasibility of using the platform in minimally invasive gynaecologic oncology procedures. However, further studies are necessary to compare its clinical outcomes, efficiency, and cost-effectiveness with other established systems.

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Minimally Invasive Sacrocolpopexy for Pelvic Organ Prolapse: Comparison of Outcomes at a Single Institution to a Metaanalysis

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Background

To evaluate the surgical technique and outcomes of laparoscopic sacrocolpopexy (LSC) and robotic assisted sacrocolpopexy (RASC) for female pelvic-organ prolapse (POP) at a single institution and to compare the findings with the data of other such studies from different databases.

Methods

24 patients underwent either laparoscopic or robotic sacrocolpopexy in a tertiary university hospital setting between 2017-2024. All operations were performed by the same surgeon. Preoperative data, peri- and postoperative outcomes were assessed. The post-op follow-up period was at > 6 months. The data obtained from our patients was compared with the most recent metaanalysis.

Results

The results revealed that RASC was associated with a significantly longer operative time (weighted mean difference, 87 min; 95% confidence interval [CI], 34,5 to 139,5 min) in accordance with the metanalysis.

Both procedures had a conversion rate of 0, neither procedure produced any major intraoperative complications, and no mesh erosions were encountered during the follow up.

There were no significant differences between the length of hospital stays, overall postoperative complications, postoperative stress incontinence, mesh erosion and effectiveness between the two groups.

Conclusions

Both RASC and LSC are safe and effective procedures for the treatment of pelvic organ prolapse. The majority of the findings predominantly concur with the conclusions of the meta-analysis, except our cohort had no mesh erosions during follow-up. RASC was associated with longer operation time and higher cost compared to LSC.

Performing subtotal hysterectomies and conserving the cervix for mesh attachment, may be the explanation for encountering no mesh erosions.

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Vaginal Cuff Dehiscence in Transgender Patients After Minimally Invasive Hysterectomy

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Background

To compare rates of vaginal cuff dehiscence (VCD) in transgender patients with cisgender patients after minimally invasive hysterectomy (MIH).

Methods

We performed a single-surgeon, retrospective cohort analysis comparing the rates of VCD in patients undergoing MIH for gender affirmation with other indications (benign, malignant, prophylactic) with our study surgeon between January, 2016, and December, 2023.

Setting: Rasoul-e Akram Tertiary Hospital Iran University of Medical Sciences (IUMS), Tehran, Iran

Patients: we perform 301 laparoscopic Hysterectomy, 129 for gender affirmation and 172 cases for other indications.

Measurements: We assessed included patients for baseline demographics, presence of risk factors for VCD, details of index hysterectomy, and details of cuff dehiscence events.

We sutured vaginal cuff of all cases by one method, right angle of vaginal cuff with one X intracorporal suture using 0 Vicryl (polyglactin) and the left side with 0 V-Loc™ 180 unidirectional absorbable barbed sutures that continue suturing to the other side. At the end of suturing, we recheck cuff vaginally

Results

Transgender patients tended to be younger at the time of surgery, but demographics were otherwise similar between both groups. In transgender cases the mean age is 25.53 years. 98.4% were virgin. 55.5% of cases had used Testosterone before procedure with discontinuing its usage 3-4 weeks prior surgery. 21.9% of them were smoker. All the cases had bilateral oophorectomy.

During five years, we have not detected any VCD. we do not recognize the higher rate of VCD in transgender group despite of Testosterones usage or different risk factors.

Conclusions

Testosterone exposure or younger age increases VCD risk cannot be derived absolutely. We suppose lower incidence of VCD in transgender cases in our study is because of our vaginal cuff closure method that suture each angle separately and cut of testosterone using that everyone must stop it maximum 3 weeks prior to surgery.

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Anatomical and functional outcomes of combined ventral rectopexy and sacro-colpo/hysteropexy for multi-compartment pelvic organ prolapse: a systematic review and metanalysis

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Background

limited data exists in the literature regarding concomitant ventral rectopexy (VRP) and sacrocolpo/hysteropexy (SCP/SHP), with existing studies being predominantly retrospective. The aim of this meta-analysis is to assess the anatomical and functional outcomes of combined VRP and SCP/SHP for the treatment of multicompartmental pelvic organ prolapse (POP).

Methods

we performed systematic research and meta-analysis from PubMed/MEDLINE and EMBASE, according to PRISMA 2020 guidelines, until 15 January 2025. Women submitted to VRP with SCP/SHP were included. Improvement of anorectal symptoms were evaluated. Postoperative anatomical relapse was reported. Re-operation rates were evaluated.

Results

We identified 209 (EMBASE) and 58 (PubMed) studies. After checking for duplicate results, and title, 21 articles were selected for abstract screening and 16 for text evaluation. Of these, 6 studies were selected for inclusion in the systematic review

Risk of bias analysis was performed for each study ranging from moderate to low

Six studies including 401 women who underwent combined VRP and SCP/SHP for multicompartment POP were included. Three studies were conducted in the USA, 1 study in France, 1 study in Italy and 1 study in the Netherlands. The design was retrospective in 5 studies and prospective in 1 study. The sample size of women who underwent a VRP and SCP/SHP ranged from 41 to 98. The median age ranged from 55.7 to 64.5 years old. Defecography was used as the main diagnostic test for preoperative assessment of posterior compartment defects. Mean follow-up ranged from 3 to 36 months.

The dichotomous meta-analysis showed a postoperative improvement of constipation/ODS [OR 0.26, 95%CI 0.10-0.68; $p=0.006$ (I^2 -test 81%, $p=0.56$)] and of AI/FI [OR 0.09, 95%CI 0.03-0.30; $p<0.0001$ (I^2 -test 70%, $p=0.04$)] after combined VRP and SCP/SHP. The proportion meta-analysis of 4 included

studies reported a subjective POP recurrence rate of 7% (95%CI: 1%-13%; I^2 -test 82.9%, $p<0.001$). The proportion metanalysis of 5 included studies for objective POP recurrence was 5% (95%CI: 1%-9%; I^2 -test 56.9%, $p=0.041$).

No serious adverse events were reported.

Conclusions

Ventral rectopexy associated to sacrocolpo/hysteropexy demonstrated to be safe and effective for women affected by multicompartement pelvic organ prolapse, providing optimal functional and anatomical results. Larger, long-term, prospective controlled studies are necessary to confirm these results.

Giant ovarian mucinous cystadenoma

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Background

Ovarian tumours with diameters exceeding 10 cm are classified as giant ovarian cysts. One of the most common types that can grow to such large sizes is the mucinous cystadenoma. The peak incidence occurs between 30 and 50 years of age.

Mucinous cystadenomas account for approximately 12–15% of all ovarian tumours.

The Prognosis is excellent for benign mucinous cystadenomas, with low recurrence rates after complete removal.

Methods

Women presenting with abdomino-pelvic masses represent a diagnostic challenge. The aim of this case report is to present a rare case of a giant ovarian cyst-specifically, a mucinous cystadenoma- which is an uncommon differential diagnosis for large abdominal masses.

Results

We report the case of a 38-year-old woman, Para 2, with no history of chronic illness, she had a appendectomy at an early age and a family history of breast cancer.

She presented to our department with chronic pelvic pain and progressive abdominal swelling over six months, without any other associated symptoms.

Physical examination revealed a soft, rounded, and fairly mobile abdomino-pelvic mass, measuring approximately 14 cm and not extending beyond the umbilicus.

Pelvic ultrasound demonstrated a latero-uterine multilocular mass measuring 14 × 12 cm. The lesion was avascular on Doppler ultrasound, without vegetations, and of uncertain origin, likely arising from the left ovary.

Further imaging (Pelvic MRI) confirmed a multilocular pelvic mass, probably of left ovarian origin, measuring 12 × 10 × 14 cm. The mass contained haemorrhagic sediment and thin septations, with no detectable solid components. It was classified as ORADS 3;

The CA 125 level in our case was at the upper limit of 35 IU/mL.

The patient underwent a left cystectomy by laparoscopic approach, The cyst was successfully removed intact, with no spillage or dissemination.

The surgical follow-ups were simple. Anatomico-pathological examination confirmed a mucinous cystadenoma of the ovary.

In our case of a large tumour (>10 cm), further digestive investigations were necessary to search for a primary digestive tumour. Esophagogastroduodenoscopy (EGD) and colonoscopy were performed and revealed no abnormalities.

Conclusions

Women with abdominal-pelvic masses constitute a challenging condition. Among ovarian tumours, mucinous cystadenomas are notable for their ability to reach considerable sizes, although such cases are relatively rare.

Its treatment is surgical, and the follow-ups are usually simple.

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Recurrent ectopic pregnancy in a tubal stump: a case report about a rare complication after (subtotal) salpingectomy

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Background

To report a rare case of recurrent ectopic pregnancy with foetal cardiac activity in a tubal stump following ipsilateral (partial) salpingectomy, and to emphasise key surgical considerations to reduce the risk of this rare complication.

Methods

Six months after undergoing a right-sided laparoscopic salpingectomy for a ruptured tubal ectopic pregnancy, a 33-year-old patient presented with acute lower abdominal pain at 7+2 weeks of spontaneous gestation. Diagnostic evaluation included transvaginal ultrasound and serial β -hCG measurements. Sonographic findings revealed an ectopic pregnancy with foetal cardiac activity and free fluid in the pouch of Douglas, prompting emergency laparoscopy.

Results

Laparoscopy revealed an intact left fallopian tube and a 4 cm hematoma-ectopic mass with cornual insertion at the right tubal stump, consistent with recurrent ipsilateral ectopic pregnancy. Approximately 200 ml of hemoperitoneum was noted in the pouch of Douglas. The mass was excised, exposing viable trophoblastic tissue within the remaining tubal remnant. The stump was fully resected up to the cornual origin. Hemostasis was secured using bipolar coagulation, and serosal closure was performed. Histopathological analysis confirmed the intraoperative findings

Conclusions

Recurrent ipsilateral ectopic pregnancy is an exceptionally rare but clinically significant complication following salpingectomy. To date, only four similar cases have been reported in the literature. The mechanisms behind these events remain unclear, though potential causes include contralateral fertilisation with nidation in the ipsilateral tubal stump, tubal recanalization due to inadequate diathermy, and sperm migration through the patent fallopian tube. Given these risks, we recommend performing a radical total salpingectomy, as it minimises the length of the tubal remnant. Simultaneously extensive coagulation of any residual tissue and closure of the serosa are essential to reduce the recurrence risk. Total salpingectomy offers a more definitive sterilisation method than tubal ligation, significantly reducing the risk of future ectopic pregnancies and enhancing long-term patient outcomes.

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A case-controlled cost analysis comparing radiofrequency conservative treatment of uterine myomas and surgical treatment by myomectomy or hysterectomy

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Background

Uterine myoma are the most commonly diagnosed benign pathologies in women of childbearing age affecting 20 to 50% of women over 30. They are symptomatic in approximately 25% of cases with abnormal uterine bleeding, pelvic pain, organ compression, and/or infertility. Asymptomatic myomas require no treatment, but symptomatic ones are treated based on location, size, and individual factors such as age and pregnancy desire. Surgical options include myomectomy (fertility-sparing) with risks such as bleeding, prolonged recovery, and higher obstetrical complications; hysterectomy (radical surgery) with risks such as adhesions, occlusion and bowel complications.

Other options are uterine artery embolization, developed in the 90s, which is a non-invasive technique that reduces myoma size but raises minor complications and questions about fertility. Myolysis, using thermal energy, is emerging as a non-invasive alternative, offering quicker recovery and improved symptoms.

The aim of this study was to report a cost analysis comparing radiofrequency and traditional surgeries in the management of uterine myomas. Secondary objectives were to report medical data (bleeding, readmission and reintervention for example).

Methods

We performed an unicentric, retrospective, case-control and age-stratified cost analysis study of radiofrequency ablation in the management of uterine myoma in a teaching hospital, compared to either hysterectomy or myomectomy. The study included women who underwent radiofrequency for uterine myoma between October 2022 and June 2024. Matched controls who underwent open or laparoscopic myomectomy for women under 42 were selected and those who underwent open or laparoscopic hysterectomy for women over 42.

Cost comparisons and comparisons in some medical outcomes were performed.

Results

A total of 73 radiofrequency procedures were performed: 48 in women under 42 and 25 in women over 42.

Regardless of age group, radiofrequency treatment leads to shorter surgical length ($p<0.01$) and hospital stay ($p<0.01$) but also less blood loss ($p=0.01$). The total cost of the procedure, including the price of the non-reusable needle, was significantly lower in the RFA group (1300 to 2118 euros less by women considering only the price of the needle and valorisation of an hour of occupation of operative room without valorisation of hospital stay and sick leave). The initial sick leave was

significantly shorter in the radiofrequency group for women under 42 and over 42 (mean sick leave for radiofrequency between 3.9 and 4.8 days compared to 26.4 to 30.6 days for open or laparoscopic myomectomy or hysterectomy ($p < 0.01$). Risk of readmission or reintervention are comparable between groups.

Conclusions

Radiofrequency ablation emerges as a promising, less invasive alternative to conventional surgery for the first-line treatment of symptomatic uterine fibroids, offering a lower overall cost.

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Post C- Sectional Tumour in the Camper's Fascia: A Case of Clear Cell Carcinoma Located Beneath the Pfannenstiel Incision

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Background

The main purpose of this case report is to highlight a rare condition in which a tumour, diagnosed as clear cell carcinoma, is located in the Camper's fascia just beneath the Pfannenstiel incision. This localization is notably uncommon and warrants attention.

Methods

A 28-year-old multiparous female patient, who had undergone a caesarean section 4 years ago, presented to my clinic with a palpable mass in her lower abdomen. Upon physical examination, a mass was identified that caused slight bulging under the skin, located just beneath the Pfannenstiel incision. Abdominal ultrasonography was performed to further evaluate the mass, revealing a solid, well-defined, 25x28 mm lesion with characteristics suggestive of a pseudocapsule. The patient reported severe pain in the area, stating that the mass had appeared three years ago and had gradually increased in size since then. Transvaginal ultrasonography was performed to assess the internal genitalia (uterus and ovaries), which showed no evidence of gynaecologic malignancy, such as endometrial thickening or ovarian masses. Following the examination, surgical intervention was deemed necessary. The surgery was performed within a week.

Results

The diagnostic report was received from the pathology department of our hospital within 13 days. The result indicated: "high possibility of Clear cell carcinoma developing on the background of endometriotic foci". The patient was promptly contacted and referred to an oncology centre for further consultation. The pathological specimen has been sent to the central facility for further evaluation, and we are currently awaiting the final results.

Conclusions

A young female patient with no gynaecological complaints, normal ultrasonographic findings without ovarian mass or endometrial pathology with normal serum CA-125 level, was diagnosed with a mass under the skin with suspected clear cell carcinoma in the context of endometriotic foci. This is an intriguing case, and no similar examples have been found in the literature. While the occurrence of endometriosis secondary to the sutures used during uterine fixation, particularly those in the Camper's fascia, is not uncommon, the presence of clear cell carcinoma in this region is a rare and interesting finding. The patient's diagnostic and treatment process is ongoing. Considering the final pathology and potential surgical or medical interventions, this case may contribute to the literature by providing insight into the deeper investigation of masses beneath the Pfannenstiel incision and the necessity of their surgical excision.

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Small bowel perforation caused by a migrated intrauterine device following uterine perforation: a rare complication

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Background

Intrauterine devices (IUDs) are highly effective long-acting reversible contraceptives, used by over 160 million women globally. Although considered safe, rare but serious complications such as uterine perforation may occur. Migration of the IUD into adjacent abdominal or pelvic organs can result in significant morbidity. While uterine perforation secondary to an IUD is a rare occurrence, bowel perforation resulting from IUD migration is an even rarer and more serious complication. Notably, most documented cases of bowel perforation involve copper IUDs. Here, we report an unusual case of ileal perforation caused by the migration of a levonorgestrel-releasing IUD (LNG-IUD). This case also featured dual-site small bowel injury, an extremely rare phenomenon-highlighting the importance of prompt diagnosis and multidisciplinary management. Written informed consent was obtained from the patient for publication of this case report.

Methods

A 38-year-old woman presented with severe abdominal pain one month after IUD insertion. A prior attempt at removal revealed the IUD was no longer intrauterine. Imaging demonstrated the IUD located posterior to the uterus with associated free pelvic fluid. Diagnostic laparoscopy identified fundal uterine perforation, and the IUD embedded in the Douglas pouch. Two separate perforations approximately 10 cm apart were identified on the ileum-a highly rare finding.

Results

The IUD was removed laparoscopically, and intraoperative general surgery consultation was performed. A midline laparotomy was conducted, and the injured bowel segments were resected with side-to-side anastomosis. The uterine perforation site was sutured, and pelvic lavage and drainage were completed. The patient had an uneventful postoperative course and was discharged on postoperative day 8. No complications were observed during a 2-month follow-up.

Conclusions

Although rare, IUD-related uterine perforation with secondary gastrointestinal injury-especially involving multiple intestinal perforation sites-should be considered in patients with unexplained abdominal symptoms following insertion. Early imaging, diagnostic laparoscopy, and multidisciplinary surgical intervention are crucial for optimal outcomes.

Training curve and docking time for robotic gynaecological surgery in UK tertiary hospital

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Background

Robotic-assisted surgery has become increasingly prevalent in gynaecology, offering benefits such as enhanced precision and reduced recovery times. However, the transition from traditional laparoscopic to robotic surgery involves a learning curve that can impact surgical efficiency. Docking time, the period required to set up and connect the robotic system to the patient, is a key factor in this learning process. Understanding how docking time evolves with experience is essential for optimizing surgical workflows and training programs.

Methods

A retrospective analysis was conducted on robotic-assisted gynaecological surgeries performed between October 2024 to April 2025 at University Hospital of Southampton. Data collected included patient demographics, surgical procedures, surgery times and docking times. The learning curve was evaluated using cumulative sum (CUSUM) analysis to identify milestones in proficiency. Docking times were compared across these 6 months.

Results

The analysis revealed a significant reduction in docking times as surgical experience increased. Surgeons with prior laparoscopic experience demonstrated a more rapid reduction in docking times. Initial docking times decreasing to 15 minutes after 10 cases. CUSUM analysis identified a learning phase up to 20 cases, after which docking times plateaued, indicating achieved competence.

Conclusions

The findings underscore the importance of structured training programs that incorporate both robotic system handling and surgical techniques. A defined learning phase, as indicated by docking time improvements, can guide training schedules and resource allocation. Further prospective studies are recommended to validate these results and explore the long-term impact of reduced docking times on overall surgical outcomes and patient satisfaction.

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Minimizing Blood Loss in Laparoscopic Myomectomy

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Background

Uterine fibroids are the most common benign tumours of the female reproductive tract and frequently require surgical treatment when symptomatic. Laparoscopic myomectomy is the preferred approach in women desiring fertility preservation. One of the major challenges of LM is controlling intraoperative bleeding, especially in the case of large or multiple myomas. The objective was to assess the effectiveness of using a bilateral temporary occlusion of the hypogastric artery using vascular clips in reducing blood loss during laparoscopic myomectomy.

Methods

We report the case of a 36-year-old nulliparous woman presenting with menometrorrhag during laparoscopic mural fibroid 7 cm deformed the uterine cavity. The patient expressed a strong desire to preserve fertility. Laparoscopic myomectomy was planned, with intraoperative temporary occlusion of both uterine arteries using vascular clips. The myoma was enucleated, and the uterine defect was closed in one layer using a baseball stitch suture. Clips were removed after completion of the myometrial repair and haemostasis. The main objective was to evaluate the impact of this technique on perioperative blood loss, which is quantified as the difference in the pre- and postoperative haemoglobin level (Delta Hb) and the postoperative blood transfusion.

Results

The procedure was completed successfully with an estimated blood loss of 100 mL. Total operative time was 90 minutes. No intraoperative or postoperative complications occurred. Haemoglobin drop was minimal ($\Delta\text{Hb} = 0.9 \text{ g/dL}$), and no transfusion or iron supplementation was needed. The patient was discharged on postoperative day 2. At the 3-month follow-up, transvaginal ultrasound confirmed normal uterine healing and vascularisation.

Conclusions

Temporary bilateral hypogastric artery occlusion using vascular clips during laparoscopic myomectomy is a simple and effective technique to significantly reduce intraoperative blood loss. This fertility-preserving approach may improve surgical outcomes, especially in patients with large or symptomatic fibroids.

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Transvaginal Ultrasound-Guided Ovarian Cyst Puncture Under Local Anaesthesia: A Single-Center Descriptive Analysis

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Background

Ovarian cysts are a frequent incidental finding in gynaecologic care and may require intervention when they become symptomatic, persist, or raise concerns regarding malignancy. While laparoscopic cystectomy remains a standard treatment, it involves surgical risk, hospitalisation, and general anaesthesia. For selected patients with benign-appearing cysts, transvaginal ultrasound-guided cyst puncture under local anaesthesia presents a minimally invasive and cost-effective alternative. Despite its potential, this approach is controversial, not yet widely adopted or documented in clinical practice [1]. Pre-interventional risk assessment is essential, and the International Ovarian Tumour Analysis (IOTA) criteria provide a validated sonographic framework to support decision-making and ensure oncological safety. This study presents real-world data from a single centre, aiming to characterise patients undergoing this procedure and assess feasibility, safety, and short-term outcomes.

Methods

We retrospectively analysed 15 gynaecological patients treated at the Department of Obstetrics and Gynaecology, Alb-Donau Klinikum Ehingen, Germany, between 2024 and 2025. All patients presented with persistent or symptomatic ovarian cysts and underwent ultrasound-guided transvaginal cyst puncture under local anaesthesia in an outpatient setting. Cysts were sonographically evaluated prior to the procedure using the IOTA classification system. Only cysts with benign features were selected. Aspirated fluid was sent for cytological analysis.

Results

The average patient age was 60.4 years (median 60). The mean cyst diameter measured 6.5 cm, and the mean aspirated volume was 119.7 ml (median 60 ml). Anatomically, the majority of cysts were located in the Douglas space (66.7%), followed by the retrovesical space (26.7%) and next to the vaginal stump (6.7%). Regarding lateral distribution, 46.7% of cysts were right-sided and 33.3% left-sided. According to IOTA classification, most cysts were categorised as B1 (73.3%), with a smaller number falling into B3 (6.7%) and B4 (20.0%); no cysts were classified as B2. Cytological analysis showed no evidence of malignancy in any case. Only one patient (6.7%) experienced cyst recurrence 8 weeks after puncture.

Conclusions

These findings support the safety and feasibility of transvaginal ultrasound-guided cyst puncture as a low-risk, minimally invasive treatment for ovarian cysts in appropriately selected patients. When guided by IOTA criteria and accompanied by cytological analysis, the procedure may help reduce the need for laparoscopic surgery in benign cases [1, 2].

References:

1. Díaz de la Noval B, Rodríguez Suárez MJ, Fernández Ferrera CB, Valdés Lafuente D, Arias Cailleau R, Pérez Arias H, Torrejón Becerra JC, Suárez Gil P, Lucio González LR (2020) Transvaginal Ultrasound-Guided Fine-Needle/Aspiration of Adnexal Cysts With a Low Risk of Malignancy. *Journal of Ultrasound in Medicine* 39:1787–1797. <https://doi.org/10.1002/jum.15283>
2. Nikolaou M, Adonakis G, Zyli P, Androutsopoulos G, Saltamavros A, Psachoulia C, Tsapanos V, Decavalas G (2014) Transvaginal ultrasound-guided aspiration of benign ovarian cysts. *J Obstet Gynaecol (Lahore)* 34:332–335. <https://doi.org/10.3109/01443615.2013.874406>

<https://esge.covr.be/cmdocumentmanagement/conferencemanager/documents/api/getdocument/14674/cmabstms/0000203660/6dda86a006ee89af17e19f24739790e35adec8254db323b713bc01d841f39d6d>

Residents' Rise in Laparoscopic Hysterectomy Mastery

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Background

Laparoscopic hysterectomy (LH) is increasingly performed due to its advantages over open surgery. However, its implementation in training programs raises questions about safety and efficiency during the learning curve.

Our study aimed to describe the learning curve of laparoscopic hysterectomy among residents of gynaecology and obstetrics.

Methods

This is a prospective bicentric study, from January 1st, 2016, to December 31, 2022. It included all patients who underwent a laparoscopic hysterectomy (+/- adnexectomy) in two gynaecology and obstetrics departments of Mongi Slim Hospital and Aziza Othmana Hospital, Tunisia.

Results

We included a total of 170 laparoscopic hysterectomy cases.

Residents began performing laparoscopic hysterectomies in 2016. Procedures performed by residents accounted for 6.7% in 2016 and increased to 29% in 2022.

The operative time was significantly shorter for procedures performed by senior surgeons (assistants, associate professors, and professors) compared to those performed by residents ($p < 0.001$).

We observed a lower rate of intraoperative incidents among residents (4.1%) compared to senior academic surgeons (7.7%). Bladder injuries were more frequent in hysterectomies performed by residents (3.2% vs. 2.6%; $p = 0.679$), although this difference was not statistically significant.

No significant differences were seen for the length of hospital stay.

Conclusions

Laparoscopic hysterectomy by residents has increased steadily since 2016, reflecting growing surgical exposure and skill acquisition. While operative times were longer for residents, complication rates were comparable to those of senior surgeons. The findings suggest a safe and progressive learning curve for residents under appropriate supervision.

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Real-world use of relugolix-combination therapy (Ryeqo) in the management of uterine fibroids in Northeast London

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Background

To evaluate real-world use and outcomes of the oral gonadotropin-releasing hormone receptor antagonist combination therapy—relugolix 40 mg, oestradiol 1 mg, and norethisterone acetate 0.5 mg (Ryeqo)—since its introduction for the treatment of women with moderate to severe uterine fibroid symptoms in Northeast London. The study assessed symptom control, fibroid size change, side effect profile, treatment duration, and subsequent clinical outcomes.

Methods

A retrospective review was conducted of women prescribed Ryeqo, between November 2022 and December 2024 across five hospitals in East London. Data collected included demographics, fibroid characteristics, clinical indications, prior fibroid-related interventions, imaging modality, treatment rationale, duration of therapy, side effects, and clinical outcomes.

Results

A total of 308 patients received Ryeqo during the study period. The median age was 46 years (range 21–61). Ethnic distribution was 37% Black, 36% Asian, and 14% White.

- Symptoms at baseline: 91% reported heavy menstrual bleeding; 39% had moderate to severe dysmenorrhoea.
- Indications for treatment: heavy and painful periods (57%), heavy bleeding alone (25%), pelvic pain (10%), and pressure symptoms (7%).

Imaging prior to treatment was performed in 95% of cases (62% ultrasound, 26% MRI, 12% both), demonstrating the fibroid burden: 29% had >10 fibroids, 44% had 2–5 fibroids, 21% had a single fibroid, and 14% had 6–9 fibroids.

Treatment rationale included: awaiting surgery (n=100), severe symptoms (n=99), avoiding surgery (n=54), delaying surgery (n=6), improving quality of life (n=9), failed previous therapies (n=8)

Duration of therapy ranged from 1 week to 2 years, with 81% using Ryeqo for >3 months, and 48% for >6 months. This resulted in 23/49 women successfully avoiding surgery, and 3/6 being able to delay surgery. The haematological response varied with a median haemoglobin increase of 7 g/dL (range –41 to +79 g/dL). Primary fibroid comparison showed a modest mean volume reduction of 3.3 cm³. Of 36 patients using Ryeqo >12 months, only one had a documented bone scan. Details on side effects were recorded in 94 patients: 53% had no reported side effect, and 47% reported at least one side effect, of which 14% experienced increased bleeding.

Subsequent interventions for patients unable to continue Ryeqo included:

- 13 laparoscopic hysterectomies
- 3 open hysterectomies
- 4 hysteroscopic resections
- 4 open myomectomies
- 3 laparoscopic myomectomies
- 4 endometrial ablations
- 4 uterine artery embolisations

Conclusions

This real-world evaluation demonstrates that Ryeqo is a generally well-tolerated and effective medical therapy for a diverse cohort of patients with symptomatic fibroids. It offers symptom relief, improves haemoglobin levels, and can serve as a bridge to surgery or as a non-surgical alternative. A number of women in our study were able to avoid or defer surgery. Given the clinical heterogeneity of fibroid presentation and the limitations of retrospective data, prospective comparative trials are warranted to more accurately assess long-term effectiveness and optimise patient selection.

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**How long does combined hormonal therapy suppress AMH levels in women with endometriomas?
Results from an exploratory analysis**

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Background

Anti-Müllerian hormone (AMH) is the most reliable biomarker of ovarian reserve (OR). Ovarian endometriosis (OMA), which affects up to 44% of women with endometriosis, is associated with an increased risk of infertility. A common treatment in patients with OMA are combined hormonal contraceptives (CHCs). Lower AMH levels have been reported in women with OMAs undergoing CHC treatment; however, the extent and timing of AMH recovery following CHC discontinuation remains unclear in this population. The objective of our study was to prospectively evaluate serum AMH levels at the initiation of hormonal therapy, during treatment, and up to three months after CHC discontinuation in women with OMAs.

Methods

This prospective, observational cohort study was conducted at a tertiary endometriosis centre between March 2020 and December 2022. Forty consecutive patients with a new OMA diagnosis were enrolled. Exclusion criteria included age <18 or >40, ovarian insufficiency, prior ovarian surgery, ongoing hormonal therapy and contraindications to CHC. Serum AMH was measured at baseline (T0), after six months of continuous oestradiol valerate 2 mg/dienogest 3 mg treatment (T1), and three months post CHC-discontinuation (T2). Secondary outcomes included evaluating AMH changes based on the presence of deep infiltrating endometriosis (DIE), OMA size and laterality, OMAs number, age.

Results

Nineteen patients completed the study. AMH levels declined significantly by 0.21 ng/mL from T0 to T2 ($p = 0.027$). No significant influence was observed based on deep infiltrating endometriosis (DIE) presence, OMA laterality, number, or age. AMH decreased more from T0 to T1 in women with OMAs <30 mm versus >30 mm ($p = 0.005$) and significantly increased from T1 to T2 in the <30 mm group ($p = 0.018$). However, overall AMH variation from T0 to T2 did not differ between size groups.

Conclusions

Accurate interpretation of AMH is crucial when counselling women with OMAs about fertility preservation. In this population, AMH levels remained significantly suppressed three months after CHC discontinuation, regardless of clinical or ultrasound findings. Although overall cyst size was not significantly associated with AMH trends, the observed pattern - greater suppression and partial recovery in smaller OMAs; milder decline during therapy with no significant post-treatment rebound in larger OMAs - may suggest a relative influence of size on functional plasticity, follicular dynamics, and hormonal responsiveness.

Overall, these findings suggest that a three-month washout period may be insufficient to distinguish the transient effects of CHC use from underlying ovarian impairment in this population. Larger prospective studies are needed to validate these results and to determine the optimal timing for AMH testing following CHC discontinuation.

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Tunisian experience: training for gynaecological endoscopy

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Background

To evaluate the outcomes of a two-year masterclass in minimally invasive gynaecologic surgery conducted at the Faculty of Medicine of Tunis among healthcare professionals from North and West Africa.

Methods

The masterclass was conducted over 2 years (2024 and 2025), with 2 separate cohorts. Each edition consisted of a 2-week intensive program totalling 80 hours, divided into 2 modules. The first 40 hours focused on theoretical foundations and recent advances. Key topics included laparoscopic principles, benign gynaecologic diseases, pelvic-perineology and urodynamics, endometriosis, oncologic surgery, and hysteroscopy from diagnosis to operative management. The second 40 hours provided supervised practical workshops, culminating in immersive surgical simulations using porcine models to replicate realistic operative conditions. Educational strategies included lectures, case-based discussions, and scenario-based simulation. Participant performance and engagement were assessed during practical sessions.

Results

The program included a total of 50 participants: 25 residents (50%), 13 private gynaecologists (26%), and 12 university hospital assistants (24%). Geographically, participants came from Tunisia (39,7%), Mauritania (6,1%), Algeria (2,4%), Guinea Conakry (2,4%), and Chad (1,2%). The structured progression from foundational knowledge to simulation-based training was well received. The high-fidelity porcine model enabled immersive practice in laparoscopic and hysteroscopic surgery within a safe learning environment. Multinational representation enhanced peer exchange and regional cooperation. However, the absence of formal certification was identified as a limitation. Participants expressed a strong interest in validated accreditation for acquired competencies.

Conclusions

This experience confirms the relevance and effectiveness of a structured, simulation-based training model in gynaecologic endoscopy within African settings. Integration of international accreditation such as GESEA is planned to enhance the program's credibility and standardization. The Tunisian experience offers a reproducible and scalable model to strengthen endoscopic expertise in resource-limited contexts.

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Fertility preservation counselling trends for young female cancer patients in Italian referral centres from 2015 to 2021

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Background

Preserving fertility in young women diagnosed with cancer is a crucial aspect of comprehensive cancer care, with a profound impact on the quality of life and the future reproductive choices of these patients. Approximately 7,000 women aged 15-39 years are diagnosed with cancer each year in Italy, but despite the availability of effective fertility preservation procedures (FPPs) and the substantial psychological impact of potential infertility, access to counselling and FPPs in Italy remains inadequate.

Methods

This study aims to assess fertility preservation counselling trends in Italy from 2015 to 2021 among women aged 15–39, across four cancer categories (breast cancer, ovarian cancer, onco-haematological malignancies, other solid malignancies). Data on the incidence of neoplasms were obtained from the Global Burden of Disease (GBD) Results Tool, which currently provides estimates up to the year 2021, extracting the number of new cancer diagnoses per year. Data on the number of counselling sessions for fertility preservation were extracted from the Italian Assisted Reproductive Technology Registry (IARTR) database. This data collection system, known as PreFerIta, was developed to collect data on Fertility Preservation (FP) treatments in oncology patients and/or those at risk of iatrogenic infertility, provided in 7 specialised ART centres across Italy. The PreFerIta database includes data on both oocyte cryopreservation and ovarian tissue cryopreservation.

Results

Between 2015 and 2021, a total of 49,188 new cancer diagnoses (95% UI: 45,000–53,500) were recorded among Italian women aged 15–39, including breast cancer, haematological malignancies, ovarian cancer, and other solid malignancies. During the same period, 2,590 fertility preservation counselling sessions were reported across seven specialised centres in Italy. Although the number of counselling sessions showed a gradual increase over time, they remained disproportionately low compared to cancer incidence. Counselling rates peaked among breast cancer patients in 2021, while rates for other malignancy types consistently remained below 4%. These findings highlight a persistent and significant gap between cancer diagnosis and access to fertility preservation counselling.

Conclusions

Despite a slight increase, access to fertility preservation counselling for young women with cancer in Italy remains inadequate. Targeted interventions, including mandatory training for specialists and the development of national guidelines, are urgently needed to address this gap and ensure that all eligible women are informed about their reproductive options.

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Evaluation of Surgical Treatment Selection According to the Characteristics and Localisation of Dermoid Cysts and Teratomas

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Background

To investigate the surgical management preferences in patients diagnosed with dermoid cysts (D) or teratomas (T) based on the characteristics and localisation of the D/T cysts identified in pathological examination.

Methods

This retrospective study evaluated the medical records of patients who underwent surgery at Gazi University Faculty of Medicine Hospital between 2008 and 2025 and were diagnosed histopathologically with a dermoid cyst or teratoma. A total of 625 patients aged between 11-79 years were included in the study. Data were analysed based on the localisation of the D/T cyst, the preoperative clinical suspicion of benign versus malignant pathology, and the surgical approach preferences over the years. Pathological specimens containing only epithelial components were classified as dermoid cysts, whereas those containing structures from the epidermal, mesodermal, and endodermal layers were classified as teratomas.

Results

When the surgical approaches were compared based on the pathological diagnosis, 28.5% (n=134) of teratomas were treated with laparotomy (L/T), 64.7% (n=304) with laparoscopy (L/S), 6.2% (n=29) with caesarean section (C/S), and 0.6% (n=6) with vaginal hysterectomy (VH). Among patients diagnosed with dermoid cysts, 29% (n=31) underwent L/T, 64.5% (n=69) L/S, and 6.5% (n=7) C/S. No statistically significant difference was found in the choice of surgical approach according to the pathological diagnosis ($p=0.19$).

According to these findings, patients with a preoperative diagnosis considered benign were more frequently operated on via laparoscopy (L/S) (65.9%), whereas those suspected to have malignancy were more often treated with laparotomy (L/T) (71.4%). A statistically significant difference was observed between the benign/malignant preoperative assessment and the choice of L/S versus L/T (65.9% vs. 71.4%, $p<0.01$).

No statistically significant difference was found in the laterality (right vs. left) of masses with malignant pathology (57.1% vs. 42.9%, $p=0.06$); however, malignant D/T cysts showed a tendency to be located more frequently on the left side. Although the proportion of left-sided localisation was higher among malignant D/T cysts, the side of the lesion (right vs. left) did not influence the choice of surgical approach ($p=0.91$). When the years from 2008 to the present were analysed, laparoscopy (L/S) remained the most commonly preferred surgical method in all years. No significant difference was found in the choice of surgical approach over time.

When pathological results were evaluated according to patient age, D/T cysts were most commonly observed in patients aged between 26-44 years. There was no statistically significant difference in the age distribution between dermoid cysts and teratomas. (38.2 ± 13.2 vs. 35.4 ± 13.8 years, $p = 0.059$).

Conclusions

The choice of surgical approach was influenced not by the localisation of the D/T cyst, but rather by the preoperative suspicion of benign versus malignant pathology. Malignant D/T cysts and cases with concurrent malignancies tended to be more common with increasing age.

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High-performance mindset and mental practice: the missing links in advancing gynaecological surgical excellence

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Background

In the operating theatre, technical skill is only part of the equation. Consistently excellent surgical performance depends on cognitive control, emotional regulation, and the ability to focus and adapt under pressure. These are not innate traits, but trainable attributes - widely recognised in elite domains such as aviation, elite sport and performance arts. Yet, in gynaecological surgery, the systematic cultivation of a **high-performance mindset (HPM)** and the use of **mental practice** remain notably underused. As surgical techniques grow more complex and minimally invasive platforms evolve, there is a growing need to support not only what surgeons do with their hands, but how they prepare, think, and recover. This work presents HPM and structured mental rehearsal as transformative yet accessible tools to optimise both training and ongoing surgical excellence - empowering both the next generation of gynaecological surgeons and experienced consultants alike.

The objective is to advocate for the adoption of HPM and structured mental practice as foundational components of surgical education and professional development in gynaecology. These concepts, grounded in cognitive science and elite performance psychology, have the potential to significantly enhance operative performance, preparedness and resilience among both trainees and established surgeons.

Methods

This presentation draws from cross-disciplinary research in cognitive neuroscience, sports psychology, and human factors engineering to translate proven high-performance strategies into surgical training. It outlines the core pillars of HPM - growth mindset, focused attention, emotional regulation, structured feedback and recovery - and maps them onto the specific demands of minimally invasive gynaecological surgery. Mental practice is presented as a low-cost, high-yield tool involving stepwise visualisation of procedures, decision points, and complication management, allowing surgeons to refine their cognitive and technical execution without physical rehearsal. Practical examples, mental rehearsal scripts and checklists tailored to gynaecological procedures such as laparoscopy, hysteroscopy, and vaginal surgery are presented as part of a scalable framework.

Results

Although traditionally underutilised in surgical education, HPM and mental practice offer immediate, practical benefits. These include improved preoperative focus, reduced intra-operative stress and enhanced procedural fluency. For trainees, mental rehearsal supports skill acquisition, reduces cognitive overload, and accelerates competence. For consultants, these tools offer a pathway to deliberate refinement, enhanced performance under pressure, and avoidance of plateau. They also support reflective practice, a core component of continuing surgical excellence.

Conclusions

In a field increasingly shaped by technology, innovation and precision, the surgeon's mindset and mental preparation remain critically overlooked. Integrating high-performance mindset and mental practice into surgical education and consultant development represents a paradigm shift - one that recognises the surgeon not only as a technician but also as a high-performance performer. This abstract invites discussion on how these principles can be embedded within gynaecological training, theatre culture and CPD frameworks to elevate both safety and excellence.

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Sizing it right: A literature-informed and practical approach to choosing the optimal laparoscopic retrieval bag for specimen extraction

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Background

Specimen retrieval is one of the main challenges in minimal access gynaecological surgeries for fibroids and adnexal masses, and cysts. Surgeons might favour mini-laparotomy for time efficiency or fear of spillage. Choosing the correct size of retrieval bag is usually an overlooked but critical decision before surgery. Incorrect size of the specimen bag might prolong the surgical time, risk of spillage, chemical peritonitis in dermoid cyst or bag rupture. there is a wide variety of specimen retrieval bags available in the market, varying in shape, size, material and design, causing uncertainty about the correct choice of retrieval bag. We are presenting an overview of the specimen retrieval bags to develop an evidence-based approach for optimal laparoscopic retrieval bag selection in gynaecological surgeries by: 1) Evaluating factors influencing retrieval bag performance through literature review; 2) Correlating preoperative imaging estimates with intra-operative outcomes; and 3) Establishing a standardised "Volume-to-Bag Ratio" (VBR) formula to guide appropriate bag selection and reduce complications. We noticed that marketed volumes do not always fully correlate with the real usable volume of each bag.

Methods

A comprehensive literature review (2010-2024) was conducted to identify factors affecting retrieval bag performance in minimal access gynaecological surgeries. We performed a retrospective analysis of 20 laparoscopic procedures involving specimen extraction, correlating preoperative imaging volume estimates with intraoperative outcomes, including retrieval success, operative time, and complications. Additionally, we conducted practical simulations using water-filled balloons of various volumes (50-6600ml), diameters (3-20cm), and circumferences to assess the true practical capacity of commercially available retrieval bags. Marketed bag volumes were compared with actual usable volumes to identify discrepancies. Based on these findings, we developed and validated a standardised VBR formula applicable to commonly available retrieval bags.

Results

The literature highlighted an alarming the risk when undersized or oversized bags are used. our retrospective analysis demonstrated that accurate preoperative volume estimation using imaging correlated strongly with successful retrieval. Simulation testing revealed that marketed bag volumes do not always correlate with the actual usable capacity. After our experiment, we developed a practical and standardised "volume-to bag ratio" (vbr) formula-tailored to commonly available bag sizes can potentially reduce spillage rates and shorten retrieval times.

Conclusions

A one-size-fits-all approach to laparoscopic retrieval bags is no longer viable. Our evidence-based VBR formula provides a practical, standardised approach to selecting appropriately sized retrieval bags based on preoperative imaging estimates. This approach has the potential to reduce spillage rates, prevent chemical peritonitis in cases of dermoid cysts, avoid bag rupture, and shorten operative times. Prospective validation in larger cohorts is warranted to further refine these recommendations across various specimen types and surgical scenarios.

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Hydronephrosis – a potential silent complication of benign gynaecological disorders

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Background

Hydronephrosis is a condition that may arise from various aetiologies, including urolithiasis, urothelial malignancies, anatomical abnormalities, and external compression. In female patients, benign gynaecological disorders—such as large ovarian cysts, uterine fibroids and deep infiltrating endometriosis—can represent significant, often silent causes of urinary tract obstruction. The development and progression of hydronephrosis are closely related to the degree and pace of obstruction and subsequent renal impairment. Chronic hydronephrosis may remain asymptomatic, even as irreversible kidney damage and functional decline develop. Therefore, in patients with known space-occupying or infiltrative gynaecological lesions, particularly under expectant management, screening of the kidneys and urinary tract is essential when clinical suspicion arises.

Methods

This case presentation highlights the diagnostic challenges and robot-assisted surgical treatment of hydronephrosis secondary to a large ovarian cyst and infiltrative endometriosis.

Results

The first-line diagnostic tool is renal sonography in the identification and staging of hydronephrosis and pelvic ultrasonography in the detection of the underlying gynaecological disorder. Importantly, incidental hydronephrosis may necessitate urgent surgical intervention. In such scenarios, preoperative evaluation of renal function and estimation of the post-decompression functional capacity are crucial for determining the feasibility of renal preservation and for planning adequate urinary drainage. The gold standard choice in assessing the individual functional contribution of each kidney to overall renal function is radionuclide renal scintigraphy with 99mTc-DMSA (dimercaptosuccinic acid) agent.

The infiltrative nature of the underlying pathology must also be considered when selecting the optimal surgical approach. When feasible, we recommend the surgical decompression of the ureter primarily. If surgical decompression is not executable without significant damage of the ureter, resection of the diseased segment is performed. In case of proximal or mid-ureteral small segment lesion with adequate ureteral mobility, primary tension-free direct end-to-end anastomosis is preferred. In case of distal ureteral involvement or long-segment ureteral defects not amenable to end-to-end repair, ureteral reimplantation to the bladder is suggested. Following the surgical procedure, systematic control of the urinary tract is necessary.

Conclusions

Imaging techniques as ultrasonography and radionuclide renal scintigraphy, are pivotal in diagnosing urinary tract involvement in gynaecological pathologies. Whenever feasible, minimally invasive,

endoscopic techniques should be prioritised to support faster recovery and exploit the advantages of augmented surgical technologies.

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vNOTES (vaginal natural orifice transluminal endoscopic surgery) in the current era of endometriosis minimally invasive surgery (MIS): Evolution, challenges and opportunities

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Background

To evaluate the role of vaginal natural orifice transluminal endoscopic surgery (vNOTES) in endometriosis management, with specific focus on preoperative assessment using ultrasound sliding sign and surgical outcomes in both conventional and robotic-assisted vNOTES approaches.

Methods

A comprehensive literature review was conducted of studies published between 2000-2024 evaluating vNOTES in endometriosis management. We analysed diagnostic accuracy of transvaginal ultrasound sliding sign for detecting pouch of Douglas (POD) obliteration and bowel involvement, and reviewed the surgical outcomes of both conventional and robotic-assisted vNOTES (RA-vNOTES) procedures.

Results

Endometriosis affects approximately 10% of reproductive-age women, with diagnostic delays averaging 7-8 years. The ultrasound sliding sign demonstrated high diagnostic accuracy for predicting POD obliteration (sensitivity 88%, specificity 94%) and bowel involvement (sensitivity 81%, specificity 95%) - critical factors for vNOTES feasibility. Conventional vNOTES showed favourable outcomes for mild to moderate endometriosis but significant limitations for deep infiltrating endometriosis (DIE), particularly with inadequate exposure for uterosacral ligament disease, bowel endometriosis, or bladder nodules. RA-vNOTES demonstrated promising results for more complex cases, with successful management of parametrial and rectal DIE, especially when complemented with ICG. Key advantages included scarless surgery with better cosmetic outcomes and fewer wound complications, reduced postoperative pain with lower VAS scores, and faster recovery with shorter hospital stays. Primary limitations included limited anterior compartment view, steep surgeon learning curve requiring advanced vaginal surgery skills and limited ergonomics.

Conclusions

vNOTES represents a promising minimally invasive approach for selected endometriosis cases, with preoperative assessment using the sliding sign being crucial for appropriate patient selection. While conventional vNOTES is suitable for mild to moderate disease, RA-vNOTES expands possibilities for managing complex endometriosis through enhanced visualisation and articulating instrumentation. POD obliteration remains the primary contraindication. Further prospective studies are needed to establish long-term outcomes and refine patient selection criteria.

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Laparoscopic surgery versus medical treatment in endometriosis-associated infertility patients: a unicentric prospective randomised controlled study concerning fertility outcomes

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Background

Endometriosis is characterised by the presence of endometrial implants outside the uterine cavity and is associated with pain and infertility. Laparoscopy is considered to be the gold standard for accurate diagnosis and treatment of Endometriosis. We have initiated a monocentric prospective randomised controlled study to evaluate the effectiveness of laparoscopic surgery of endometriosis versus only medical treatment on fertility outcomes. The study was well designed and took into consideration a lot of important factors, which could influence the pregnancy results with the aim of clearly stratifying evidence-based therapy strategies for patients with endometriosis-related infertility.

Methods

A total of 350 patients, from January 2015 until December 2023, between the ages of 25 and 40 years with pelvic Endometriosis complicated with infertility, were prospectively blindly randomized in group A (200 women) which underwent laparoscopy in our hospital, versus group B (150 women) which did not have laparoscopy but medical treatment with contraceptives with or without Gonadotrophin Releasing Hormone-agonist (GnRh-a). All these 350 women, in these two groups, were followed up for at least 16 months to assess fertility outcomes. The two groups were well matched according to age, hormonal, status, Anti -mullerian Hormone (AMH), Body Mass Index (BMI), secondary diseases, sperm quality and quantity of the man, infertility types: primary or secondary infertility, revised- American Fertility Society grading (r-AFS g) and treatment with GnRh-a in advanced stages of endometriosis and other characteristics to avoid bias. The laparoscopies were all performed by the same two experienced gynaecologists of the clinic with the goal of complete excision of endometriosis with tissue-sparing approaches for ovarian preservation. All statistical analyses were conducted using SPSS Statistics, version 25.0 (IMB Corp. Armonk, NY USA). P values <0,05 were considered statistically significant. Primary end results of the study were the investigation of pregnancy rates, and secondary outcomes were live birth rates and miscarriages.

Results

150/200 patients (75 %) of group A conceived, whereas only 50/150 (33,33%) of group B conceived, respectively. Univariate and multivariate logistic regression using all the above-mentioned factors indicated that treatment with laparoscopic surgery, especially when endometriotic lesions were bigger than 3 cm, was positively correlated with pregnancy rates and live birth rates and negatively with miscarriages. If the endometriotic lesions were less than 3 cm, there were no statistically significant results with laparoscopic surgery versus medical therapy in the subgroup of patients which responded to medical treatment.

Conclusions

In this unicentric, prospective randomized controlled study, we found that treatment with Laparoscopic surgery in endometriosis related infertility patients was statistically significant key factor which influenced positively the pregnancy outcomes.

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Bilateral Endometrioid Ovarian Carcinoma Presenting as a Tubo-Ovarian Abscess in a Postmenopausal Woman: A Rare Case of Malignancy Arising from Endometriosis

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Background

Tubo-ovarian abscesses (TOAs) are typically seen in premenopausal women and are most often caused by pelvic inflammatory disease (PID). In postmenopausal women, such presentations are rare and warrant thorough evaluation for atypical or malignant causes. Endometriosis-associated ovarian cancer (EAO), particularly endometrioid and clear cell carcinomas, remains an uncommon but recognised complication of longstanding or atypical endometriosis, often presenting insidiously or with misleading features.

Methods

A 53-year-old para 2 woman, five years postmenopausal, presented with intermittent vaginal spotting and mild left iliac fossa pain. Initial investigations, including transvaginal ultrasound, hysteroscopy, and endometrial biopsy, were reassuring, showing atrophic endometrium and no uterine pathology. However, over the subsequent two months, her pain worsened, accompanied by low-grade fever and systemic symptoms. Elevated inflammatory markers and imaging findings of a complex 8 cm left adnexal mass led to a diagnosis of TOA. She was treated with intravenous antibiotics and underwent laparoscopic drainage. *Escherichia coli* was cultured, and her symptoms briefly improved.

Despite this, the patient experienced recurrent admissions with ongoing pelvic pain and raised inflammatory markers. A follow-up CT scan revealed a persistent multiloculated mass with solid components. A laparoscopic abscess drainage with bilateral salpingo-oophorectomy was performed three months after initial presentation. Intraoperatively, the left adnexal mass was densely adherent to the pelvic sidewall and sigmoid colon but was successfully excised.

Results

Histology revealed **bilateral endometrioid adenocarcinoma** arising in atypical endometriosis. The left tumour measured 6.5 cm, was moderately differentiated (FIGO grade 2), and extended to the ovarian surface. Unexpectedly, the right ovary also contained a 1.2 cm endometrioid carcinoma within an endometriotic cyst. Both fallopian tubes showed chronic inflammation but no malignancy. Peritoneal washings were negative, and no lymphovascular invasion was seen. The case was discussed at the regional gynaecological oncology MDT and staged as FIGO **IC2** ovarian cancer. The patient was referred for **completion staging surgery** and consideration of **adjuvant chemotherapy**.

Conclusions

This case highlights a rare presentation of **bilateral endometrioid ovarian carcinoma arising from endometriosis** in a postmenopausal woman, initially mimicking a tubo-ovarian abscess. It underscores the importance of maintaining a high index of suspicion for malignancy in atypical TOAs, especially in postmenopausal women or where there is poor response to antibiotics. This case also

emphasises the malignant potential of endometriosis and the diagnostic challenges it may pose. Early multidisciplinary involvement and thorough follow-up were crucial to ensuring appropriate oncological management and optimising prognosis.

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Characteristics of women undergoing office hysteroscopy and the factors affecting its outcome in a public tertiary hospital: A cross-sectional study

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Background

Office hysteroscopy (OH) is gaining acceptance at our institution with the opening of the Women's Wellness Center in 2023. The centre offers office-based hysteroscopy, a see-and-treat approach that eliminates the need for anaesthesia and hospitalisation. This study aims to determine the demographic and clinical factors of patients who underwent OH and identify factors that may affect the outcome of the procedure.

Methods

A single-centre retrospective cross-sectional study of women who underwent OH from January to December 2024. Medical records were reviewed, and descriptive statistics were used to summarise patient characteristics and outcomes. Categorical variables were compared using chi-square or Fisher's exact tests, and logistic regression was used to identify factors associated with procedure outcomes. A p-value of <0.05 was considered statistically significant.

Results

A total of 108 patients who satisfied the inclusion criteria underwent OH between January and December 2024. The mean patient age was 43.1 years old, with a significant majority being premenopausal (80.6%) and multiparous (88%). Notably, most of these patients had previously delivered vaginally (71.3%). Based on body mass index (BMI), the majority were overweight (33.3%), normal weight (30.6%), and obese class 1 (23.1%). The leading indications for OH were bleeding disorders (52.8%), followed by displaced IUD (21.3%) and post-treatment surveillance (19.4%). These patients mostly underwent targeted endometrial biopsy (47.2%), diagnostic hysteroscopy (19%), IUD removal (19%), and polypectomy (13.6%). The procedures were successfully completed in 95.4% of cases. A test of association was done and revealed no correlation between procedural outcomes and age ($p = 0.9042$), parity ($p = 0.3769$), previous mode of delivery ($p = 0.6307$), BMI category ($p = 0.7336$), and menopausal status ($p = 0.9744$).

Conclusions

The demographic and clinical factors of patients included in this study were age, parity, previous mode of delivery, BMI, and menopausal status. The majority of these women were premenopausal, multiparous with previous vaginal deliveries and overweight. A high success rate (95.4%) was achieved across the diverse group. However, statistical analysis demonstrated that the study factors, namely, age, parity, previous mode of delivery, BMI, and menopausal status, did not affect the outcome.

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A rare case of small bowel herniation through a broad ligament defect: a diagnostic and surgical challenge

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Background

Acute lower abdominal pain in women often presents a diagnostic challenge for both gynaecologists and surgeons. Internal hernias are uncommon, in which abdominal organs protrude through a peritoneal or mesenteric defect. A herniation through the broad ligament is especially rare and constitutes only 4% of internal hernias. We report a case of small bowel herniation through a broad ligament defect, which was initially suspected to be an ovarian torsion.

Methods

A 40-year-old woman presented to the emergency department with a one-day history of severe lower abdominal pain and multiple episodes of vomiting. She was referred to the gynaecologist. She had no previous medical or surgical history, with seven previous vaginal deliveries. On examination, she was tender in the right lower quadrant with voluntary guarding. Her vitals and bloods, including inflammatory markers, lactate and electrolytes, were within normal limits. Ultrasound imaging revealed a mass in the right adnexa, raising concern for possible adnexal torsion. The patient was taken to the theatre for a laparoscopy.

Upon laparoscopy, the gynaecologists noted normal ovaries and fallopian tubes with no evidence of adnexal torsion. However, she had an unexpected loop of small bowel that had herniated through a right-sided broad ligament defect. The small bowel was oedematous, but there was no evidence of ischemia or necrosis.

The general surgeon was called following the findings at laparoscopy, and the bowel was carefully reduced, with a good return of perfusion and peristalsis noted. The broad ligament defect was then closed with continuous sutures to restore normal anatomical integrity and prevent any further herniation. Postoperatively, early mobilisation and a light diet were encouraged. She had an uneventful recovery and was discharged after 2 days.

Results

Broad ligament defects are rare and may lead to small bowel herniation, presenting with symptoms that can mimic those of ovarian torsion. This case highlights the importance of a thorough clinical assessment, the use of ultrasound to aid diagnosis, early surgical intervention, and working closely with other specialities, such as surgeons, for the best patient outcome. Early recognition and repair of such defects are essential to avoid complications such as bowel strangulation, necrosis, or further herniation. While ovarian torsion remains a primary concern, clinicians need to maintain a broad differential diagnosis when female patients present with acute abdominal pain.

Conclusions

This case represents a rare and interesting presentation of small bowel herniation through a broad ligament defect, highlighting the need for careful assessment and timely intervention. Clinicians

should consider the possibility of uncommon anatomical defects in women with acute abdominal pain. Prompt intervention by laparoscopy is safe and will prevent unnecessary morbidity.

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Fertility-preserving management of ovarian torsion

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Background

Ovarian torsion is a significant gynaecologic emergency characterised by axial rotation of the ovary, potentially leading to ischemia and necrosis due to arterial obstruction. In addition to acute presentations, torsion can also manifest in chronic or intermittent forms involving venous and lymphatic obstruction, resulting in ovarian swelling. Despite guideline recommendations favouring ovarian preservation, oophorectomy remains a common surgical outcome. Increased awareness of the clinical spectrum of ovarian torsion and its appropriate surgical management is necessary, particularly in young women for whom fertility preservation is a priority.

Methods

This study is a literature review and visual demonstration of perioperative management strategies for ovarian torsion, conducted at the Medical University of Vienna, Department of Obstetrics and Gynaecology. Two clinical cases were presented: one involving acute ovarian torsion with ischemia, and another demonstrating chronic torsion with massive ovarian oedema. Management included laparoscopic detorsion, cystectomy on an ischemic ovary, and oophoropexy to the pelvic sidewall and utero-ovarian ligament. Radiologic images and intraoperative video footage were used for educational demonstration.

Results

Both cases were successfully managed with conservative laparoscopic surgery, leading to resolution of pain and restoration of normal ovarian size and morphology as verified by postoperative ultrasound imaging. These outcomes support the feasibility and effectiveness of ovary-preserving surgical techniques in managing both acute and chronic ovarian torsion.

Conclusions

Despite clinical guidelines advocating for ovarian preservation, oophorectomy remains frequently employed in cases of ovarian torsion. The presented cases underscore the importance of recognising the variable presentations of ovarian torsion and employing conservative surgical techniques to preserve ovarian function and fertility. Enhanced clinical awareness and adherence to fertility-preserving practices are essential in optimising outcomes for young women with ovarian torsion.

<https://player.vimeo.com/video/1087324037?autoplay=1>

Lower urinary tract fistulas as a complication of oncological treatment – a single centre retrospective analysis

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Background

Lower urinary tract fistulas (LUTFs) are a rare but significant complication after gynaecologic oncology treatment, with a notable impact on patient quality of life. The objective of this study was to analyse the incidence, aetiology, management, and outcomes of LUTFs following oncologic treatment at our tertiary gynaecology centre.

Methods

We performed a retrospective analysis of all patients treated for LUTFs at the Department of Gynaecology, University Medical Centre Ljubljana, from January 2019 to March 2025. Data collected from our electronic archives included primary diagnosis and its treatment type, fistula type, diagnostic approach to fistulas, its management strategy and outcomes. Diagnostic workup of fistulas consisted of cystoscopy, methylene blue instillation into the bladder and imaging, including CT urography.

Results

Twenty patients were treated for LUTFs during the study period. Ten patients had vesicovaginal fistulas (50%), seven had urethrovaginal fistula (35%), one had a urethrovaginal fistula (5%) and one had a urethrovaginal fistula (5%). One patient had both a vesicovaginal and ureterovaginal fistula (5%).

Twelve patients (60%) had a history of gynaecologic malignant disease, most commonly cervical cancer (9/12; 75%). Among oncological patients, six fistulas (6/12; 50%) developed after primary surgical treatment, of which five developed after open abdominal approach, four fistulas (4/12; 33.3%) developed as a consequence of adjuvant surgery of previously radiated tissue and two fistulas (2/12; 16.7%) developed after primary surgery followed by adjuvant radiotherapy, in both cases more than 30 years after treatment of the primary malignancy. The remaining eight patients (40%) had a fistula identified following surgical treatment of benign pathology.

In the group of patients whose fistulas resulted from malignant disease, conservative management was used in four cases (4/12; 33.3%). In five cases (5/12; 41.6%), the fistula was closed via open abdominal surgery, in one case (1/12; 8.3%) via a vaginal approach, and in two cases (2/12; 16.7%) with robot-assisted laparoscopic surgery. In all cases, except for two, treatment was successful (83.3%). To date, none of these patients has experienced a recurrence of the fistula.

Conclusions

According to our study, the most common cause of fistulas was surgery for cervical cancer with an open abdominal approach. No malignant fistulas were observed after primary laparoscopic treatment.

Our findings confirm that LUFTs are a complex complication of oncologic treatment, significantly affecting patients' quality of life and requiring an individualised diagnostic and therapeutic approach. Although minimally invasive techniques are becoming increasingly important for surgical reconstruction, as they allow less invasive procedures, greater precision, and faster recovery, in our series, most reconstructions were performed via the open abdominal approach by a multidisciplinary team, including both gynaecologists and urologists.

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A Case Report: Gestational Trophoblastic Disease Creating Diagnostic Uncertainty with Imaging and Pathology Findings

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Background

Gestational Trophoblastic Disease (GTD) is a rare group of disorders characterised by pregnancy-related trophoblastic proliferation, ranging from benign to malignant forms. Early diagnosis and appropriate treatment are crucial for its prognosis. This report discusses a challenging GTD case with atypical presentation and diagnostic difficulties.

Methods

A 43-year-old female, gravida 13, presented with suspected ectopic pregnancy. Her beta-hCG levels were monitored, showing significant fluctuations. Imaging included contrast-enhanced pelvic and abdominal MRI and oncological PET/CT. Pathology examinations were performed on initial curettage material and subsequent total laparoscopic abdominal hysterectomy and bilateral salpingectomy specimens. Medical oncology consultations were also conducted to guide management.

Results

Beta-hCG levels fluctuated, not definitively indicating a typical molar pregnancy. Imaging results were equivocal; MRI suggested adenomyosis, while PET/CT showed a focal hypermetabolic appearance in the uterine fundus and minimal FDG retention in the endometrium. Initial curettage pathology did not show molar findings. However, the hysterectomy material revealed chronic cervicitis, inactive endometrium, congestion, an adenomatoid tumour (0.3 cm), and a foreign body with multinucleated giant cell reaction. Adenomatoid tumours are benign mesothelial tumours, rarely co-existing with GTD. Medical oncology consultations initially did not consider hydatidiform mole despite high beta-hCG, and methotrexate (MTX) treatment was debated but not initiated off-label.

Conclusions

This case highlights the significant diagnostic uncertainty and management challenges in GTD cases with atypical presentations. The fluctuating beta-hCG, ambiguous imaging, and unusual histopathological findings, including an adenomatoid tumour, underscore the complexity. An interdisciplinary approach involving gynecologic oncology, medical oncology, pathology, and radiology is essential for optimal diagnosis and treatment of such challenging GTD cases
<https://esge.covr.be/cmdocumentmanagement/conferencemanager/documents/api/getdocument/14471/cmabstsms/0000210560/a2f6afbbf66f219bd54992ef1a8a2a36f60f53e0feb2b82258e53f8ebea1dacc>

Cervical erosion and intrauterine migration of abdominal cerclage material identified during routine hysteroscopy: a rare complication

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Background

Abdominal cerclage is an established intervention for cervical insufficiency, particularly in cases of prior mid-trimester pregnancy losses. Unlike transvaginal cerclage, abdominal cerclage materials are typically not removed at delivery. While generally considered safe, non-absorbable tapes may, in rare cases, erode surrounding tissues or migrate. This risk may be increased in patients with prior caesarean sections due to altered lower uterine segment anatomy and scarring.

Methods

A 38-year-old woman (G4P0A4), with a history of two second-trimester pregnancy losses (twin pregnancy-25th week abortion) and 3 early miscarriages, underwent prophylactic abdominal cerclage using non-absorbable Mersilene tape, prior to assisted conception treatments. Ten months post-procedure, she underwent routine diagnostic hysteroscopy for menstrual irregularity.

Results

Hysteroscopy revealed a segment of Mersilene tape protruding into the endometrial cavity from the posterior cervical isthmic region. The patient was asymptomatic and had no sonographic findings suggestive of uterine dehiscence. The appearance was interpreted as localised cervical erosion and partial migration of the cerclage, likely due to pressure and anatomical distortion in a previously scarred uterus.

Conclusions

Intrauterine exposure to abdominal cerclage tape is rare but should be considered in women with prior caesarean section or lower uterine scarring. Hysteroscopy may incidentally detect such findings. Clinicians should be aware of this possibility during fertility evaluations or hysteroscopic procedures. Individualised monitoring and patient counselling are advised

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Well-differentiated Papillary Mesothelioma (WDPM) of the Peritoneum, Case Report and Literature Review

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Background

Well-differentiated papillary mesothelioma (WDPM) of the peritoneum is a rare neoplasm characterized by papillary structures lined by bland mesothelial cells. Predominantly affecting women of reproductive age, WDPM often presents incidentally during surgeries for other conditions. Despite its generally indolent behaviour, the potential for recurrence and rare progression to malignant mesothelioma necessitates a thorough understanding of its clinical and pathological features.

Methods

A 43-year-old woman presented with chronic pelvic pain and underwent a laparoscopic-assisted supracervical hysterectomy (LASH) with bilateral salpingectomy. During surgery, multiple papillary lesions were discovered on the pelvic peritoneum and serosal surfaces. The visual appearance raised suspicion for a neoplastic process, and biopsies were obtained.

Initial pathology was inconclusive, and the samples were referred to a tertiary pathology centre. There, the diagnosis of well-differentiated papillary mesothelioma was confirmed. A second laparoscopy was scheduled, and visible lesions were surgically debulked. The patient has since been followed in outpatient care, with no evidence of disease progression one year post-operatively.

Results

- **Demographics:** WDPM predominantly affects women (approx. 80%) with a median age of 35–45 years. Many cases are discovered incidentally during surgery for infertility, endometriosis, or adnexal masses.
- **Aetiology:** No strong or consistent link to asbestos exposure has been established. The role of hormones and chronic inflammation remains speculative.
- **Clinical Presentation:** Most patients are asymptomatic. When present, symptoms include non-specific pelvic pain, bloating, or menstrual irregularities.
- **Diagnosis:** Diagnosis is frequently delayed or misclassified due to its overlapping features with serous tumours or reactive mesothelial processes. Immunohistochemical panels are critical for differentiation but require experienced interpretation.
- **Management Approaches:**
 - Surgical resection (diagnostic or therapeutic) is commonly the first intervention.
 - Surveillance is favoured in patients with localised lesions and no evidence of progression.

- Chemotherapy and radiation are not typically indicated due to the tumour's low malignant potential.
- Only a few isolated reports exist of WDPM transforming into diffuse malignant mesothelioma, often after prolonged latency.
- **Prognosis:** Excellent overall. Recurrence is rare (<5%), and mortality directly attributable to WDPM is exceedingly uncommon. Most patients remain disease-free long-term with surveillance.

Conclusions

This case emphasises the diagnostic and therapeutic uncertainty surrounding WDPM. Though benign in behaviour, its atypical presentation can mimic malignancy, leading to potentially unnecessary radical procedures. Accurate pathology review is essential, and clinicians should maintain a high index of suspicion when encountering peritoneal papillary lesions.

In women of reproductive age or those undergoing gynaecologic surgery, conservative management with close follow-up appears to be safe and appropriate. Literature supports a shift away from aggressive treatment toward individualised, risk-adapted care.

Further multicentre case collection and prospective data are needed to establish evidence-based guidelines for the diagnosis, surveillance, and long-term management of WDPM.

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The use of low-fidelity simulation in maximising obstetric and gynaecological surgical training

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Background

Obstetrics and Gynaecology (O&G) surgical training faces significant challenges, including inconsistent simulation opportunities, reduced exposure to key procedures, and limited operative experience. Post-COVID surgical schedules, which prioritise high-volume, low-complexity cases, have further restricted training opportunities, particularly for foundational procedures such as abdominal hysterectomy and ovarian cystectomies. Additionally, work-hour restrictions compound these limitations. Simulation-based training has emerged as a crucial supplement to real-world operating room experience. Informed by Kolb's experiential learning theory, simulation enables learners to engage in concrete experiences, reflective observation, abstract conceptualisation, and active experimentation. Compared to laparoscopic simulation, open simulation offers enhanced haptic feedback, more accurately replicates tissue handling and suturing, and allows trainees to develop the intricate skills essential for open surgeries.

Methods

This prospective cohort study employed low-cost, low-fidelity simulators to replicate three key procedures: open abdominal hysterectomy, laparoscopic ovarian cystectomy, and postpartum haemorrhage compression sutures. Simulators were constructed using materials sourced from craft stores for under £50. Three in-person training sessions incorporated pre-tests, a 20-minute instructional presentation, hands-on simulation practice, and post-tests. Participants—O&G residents—rated their confidence on a three-point scale ("not at all confident," "somewhat confident," "very confident"). Anonymity was maintained, with results stratified by training grade.

Results

Baseline surveys highlighted significant gaps in procedural experience: 80% of participants had not performed an abdominal hysterectomy, 60% had not performed a laparoscopic ovarian cystectomy, and 75% had not applied postpartum haemorrhage compression sutures. Moreover, 85% lacked prior simulation training. Participants rated the simulation highly effective (average score: 4.2/5), with 90% describing it as "very effective" or "somewhat effective." Skills gained were deemed transferable to real-life surgeries (average score: 4.0/5), with 88% agreeing these could be applied in the operating room. All participants supported integrating simulation-based training into O&G curricula. Identified challenges included limited facility access (70%) and perceived lack of realism (50%).

Conclusions

Low-fidelity simulators provide a cost-effective and scalable solution to address training gaps in O&G surgery. High ratings for effectiveness and skill transferability indicate their potential as a valuable adjunct to traditional education. However, barriers such as facility access and realism must be addressed. Further studies are warranted to evaluate the long-term impact of simulation-based training on surgical proficiency and patient outcomes.

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Concomitant vNOTES risk-reducing bilateral salpingo-oophorectomy at the time of mastectomy in women with (BRCA gene and breast cancer: Pilot study

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Background

BRCA-associated hereditary breast and ovarian cancer is characterised by increased risk for breast and ovarian cancers as well as malignancies, e.g. prostate. BRCA 1/2 gene mutation is associated with a 60% lifetime ovarian cancer risk compared to the population prevalence of 1%. Risk-reducing bilateral salpingo-oophorectomy (RRBSO) reduces ovarian cancer by 96% in these women and is recommended after the ages of 35 and 45 years. While conventional laparoscopy (CL) is a benchmark for RRBSO, vaginal Natural Orifice Transluminal Endoscopic Surgery (vNOTES) is emerging as an alternative route with good optical visibility, avoidance of abdominal incisions, less pain and faster recovery. We describe novel concomitant vNOTES BSO at the time of mastectomy in women with BRCA gene mutation and breast cancer.

Methods

Women with breast cancer and BRCA gene mutation scheduled for mastectomy were offered concomitant RRBSO through the vNOTES approach. Data collected included age, BMI, Ca-125 levels, duration of surgery, estimated blood loss (EBL), length of stay, VAS at 24 hours, perioperative complications, sexual function (FSFI-6), and recovery status (RI-10). A 10 mm 7 cm transvaginal access platform was inserted following posterior colpotomy, and a 30° laparoscope was used for visualisation. RRBSO was performed using endoscopic graspers and Voyant Advanced Bipolar Device, and the specimens were retrieved through a posterior colpotomy incision. As recommended by current American National Comprehensive Cancer Network (NCCN) guidelines, salpingectomy was performed to the level of cornu and the ovarian pedicle was excised distally to include up to 2 cm margin (fig 1). Peritoneal washing was performed (fig 2) and bowel, omentum, appendix and pelvic organs were inspected. The colpotomy incision was repaired using continuous polyglactin Vicryl 1 sutures.

Results

So far, three women underwent concomitant vNOTES RRBSO and mastectomy. Median values were as follows: age 44 years, Ca-125 11 u/mL, BMI 29 kg/m³, operative time 35 mins and postoperative stay 12.2 hours. There were no perioperative complications. Median 24-hour VAS pain score was 2, sexual function pre- and post-procedure (6 weeks) appeared unaffected by the vNOTES approach (median score 6 vs 6) and normal activity resumed within 8 days (RI-10). Histology of the fallopian tubes and ovaries was benign in all cases. While the NCCN guidelines for RRBSO were achievable through vNOTES, the main limitation was the inability to visualise the anterior surface of the uterus and environs through a posterior colpotomy approach (despite using an angled laparoscope).

Conclusions

vNOTES RRBSO performed at the same session as mastectomy avoids repeat anaesthesia and does not appear to delay recovery. This route is more cosmetic, has a low pain score and avoids

complications associated with CL. Our findings support adoption of vNOTES as a patient-friendly alternative which can be performed concomitantly at the time of mastectomy.

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Four-tissue clamp technique for direct trocar insertion in morbidly obese patients

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Background

Morbid obesity causes anatomical and technical difficulties in laparoscopic surgery. The most important of these difficulties is safe entry into the abdomen. To describe a new technique with four tissue clamps for laparoscopic direct trocar entry in morbidly obese patients.

Methods

In morbidly obese patients (BMI > 40 kg/m²), a 10 mm skin incision was made, and four tissue clamps were placed in the 1-5-7-11 direction. After the 10 mm skin incision was made, the skin and subcutaneous tissues were deeply grasped with laundry clamps 5 cm away from the incision to form a square shape. After the 4 laundry clamps were placed with maximum upward and outward traction, the abdomen was entered directly with a trocar. The success rate and complications in the first attempt were reported.

Results

In 39 (87%) of 45 morbidly obese patients (BMI=44.6-48 kg/m²), abdominal access was successfully achieved on the first attempt. In 3 (50%) of 6 patients who failed on the first attempt, the second access was successfully achieved. The Hasson open access technique was used in the remaining 3 cases. In none of the 42 cases in which abdominal access was performed with the 4-clamp technique did major complications such as major vascular injury, intestinal injury, or other visceral organ injury occur.

Conclusions

The 4-clamp technique has been described as an easily applicable, highly successful, and safe technique for direct trocar insertion into the abdomen in the morbidly obese patient population. However, randomised controlled trials are needed on this subject.

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Scar Ectopic Pregnancy: Laparoscopic excision and fertility-sparing management

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Background

Caesarean scar ectopic pregnancy, occurring in approximately 1 in 2000 pregnancies, involves implantation into a myometrial defect from a previous uterine incision. This condition can lead to severe complications such as haemoperitoneum, haemodynamic shock, and maternal death if not promptly diagnosed and managed. While many cases are treated with ultrasound-guided surgical evacuation, laparoscopic full-thickness repair may be necessary in cases untreated by suction curettage.

Methods

Case Presentation: We present a surgical video of a 26-year-old woman with one previous emergency Caesarean section presented at 7 weeks of gestation with pain and bleeding. Ultrasound revealed a Caesarean scar ectopic pregnancy, with a gestational sac measuring 27.8 x 19.2 x 23.1 mm and a live foetal pole within the scar. The patient was admitted and initially consented to an Evacuation of Retained Products of Conception (ERPC). Due to suboptimal rising β -hCG levels post-ERPC, she subsequently underwent a laparoscopic resection of the ectopic pregnancy. Intraoperatively, a 25 mm ectopic pregnancy was identified on the left lateral serosal surface of the scar. The procedure was completed without complications, and the patient was discharged with instructions for follow-up.

Results

Histology for both operations confirmed the presence of ectopic pregnancy tissue. At her 6-week post-operative follow-up, she had a normal period and a negative urine pregnancy test. She is currently pregnant and 24 weeks.

Conclusions

Timely diagnosis and proficient surgical management are essential in managing Caesarean scar ectopic pregnancies, with ultrasound playing a crucial role in guiding treatment options.

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Long-term outcomes of surgical excision of deep endometriosis of the rectum. Ten-year follow-up of a randomised trial

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Background

Data concerning long-term outcomes of excision of deep endometriosis infiltrating the rectum (DIER) are scarce in terms of recurrences, rectal function or fertility. To provide new information in this field, we report 10-year outcomes of patients enrolled in ENDORE randomised controlled trial (ERCT) (NCT01291576).

Methods

Patients with symptomatic DIER with more than 2 cm area and surgically managed at Rouen University Hospital were enrolled in ERCT from March 2011 to October 2013. They were randomised between conservative vs. radical surgery (respectively CS and RS). The main endpoint was a combined variable assessing the digestive and urinary function, and secondary endpoints were fertility outcomes, recurrence rate, and scores of quality of life, gastrointestinal and urinary function. The follow-up was 10 years.

Results

There were 27 women enrolled in the CS arm (15 disc excisions, 10 shavings and 2 conversions to rectal resections) and 28 in the RS arm receiving rectal resections. One patient asked to be deleted from the study after 2 years, 1 changed the gender, and 3 were lost to follow-up after respectively 6, 8 and 9 years (9.1% of loss of follow-up at 10 years).

Rectal recurrences occurred in 3 women (5.5%). Postoperative pregnancy rate was 85.3%, with 64.4% of natural conceptions. No significant differences in endpoints were observed between CS and RS. The improvement of gastrointestinal and urinary scores has been constant for 10 years. Reoperation rate for pain relapse was 10.9% and routinely included hysterectomy for adenomyosis.

Conclusions

Both CS and RS are efficient in the management of DIER, and the improvement is constant during the 10 years after the surgery. Pregnancy rate is excellent, with a high rate of natural conceptions. Rectal recurrences are rare. Surgery may be reasonably proposed with good outcomes in the long run.

Comparing the Incidence of Focal Endometrial Pathology in Patients with Post-Menopausal Bleeding Versus Continuous Combined HRT Users with Unscheduled Bleeding: A Retrospective Analysis

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Background

Postmenopausal bleeding (PMB) refers to vaginal bleeding occurring at least one year after the final menstrual period in individuals not using hormone replacement therapy (HRT). Approximately 10% of patients presenting with PMB are diagnosed with endometrial cancer, with 90% of these cases initially presenting with vaginal bleeding¹. Unscheduled bleeding (USB) on continuous combined HRT (ccHRT) is defined as irregular bleeding during the expected 'bleed-free' period, affecting up to 40% of users². Both PMB and USB often lead to urgent suspected cancer (USC) referrals.³ In our unit, patients with PMB and an endometrial thickness (ET) ≥ 4 mm and ccHRT users with ET ≥ 5 mm were offered diagnostic hysteroscopy +/- endometrial biopsy. Operative hysteroscopy was performed for cases with focal pathology.

The study aimed to compare the incidence of hyperplasia, atypia and endometrial cancer within focal pathology in patients presenting with PMB versus those with USB on ccHRT.

Methods

A retrospective analysis was conducted on 1275 patients referred to the PMB clinic between 2022 and 2023. Of these, 756 presented with PMB and 519 with USB on ccHRT; 22 patients were excluded. Data was collected from clinical notes, ultrasound reports and histology findings from pipelle biopsies and operative hysteroscopies.

Results

In patients with PMB, the mean age was 62.2, with a mean BMI 31.7. In the USB on ccHRT cohort, the mean age was 56.1, with a mean BMI 29.7.

Among patients with PMB, 38%(276/734) underwent diagnostic hysteroscopy, with 14%(105/734) requiring operative hysteroscopy for focal pathology. Histology showed that 85% of polyps were benign, 3% had simple hyperplasia, 8% had atypical hyperplasia, and 4% had malignant changes within endometrial polyps. In the USB on ccHRT cohort, 46%(238/519) underwent diagnostic hysteroscopy with 13%(69/519) requiring operative hysteroscopy. Of the polyps identified, 95% were benign and 5% exhibited simple hyperplasia. No cases had atypical hyperplasia or malignancy were found within endometrial polyps.

Including samples sent for endometrial sampling, the overall incidence of atypical hyperplasia was 1.5% in the PMB group and 0.4% in the USB on ccHRT group. The incidence of cancer was 5.3% in the PMB cohort compared to 0.8% in the USB group.

Conclusions

This study highlights a significantly higher risk of atypia and endometrial cancer in PMB patients compared to USB on ccHRT, particularly within focal endometrial pathology. PMB patients exhibited over three times the risk of atypia and over six times the risk of malignancy, this supports the need

for prompt evaluation under the USC pathway. In contrast, the low malignancy rate in the USB cohort suggests patients may be over-investigated, a tailored referral pathway may be more appropriate. These findings also validate the current ET thresholds as effective triage tools. They also highlight the importance of patient-centred counselling to guide expectations and support shared decision-making.

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Computer Vision for Critical View of Safety Assessment in Sentinel Node Dissection for endometrial and cervical cancer (LYSE study).

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Background

This study aims to evaluate the feasibility of video-based assessment rate of Critical Views of Safety (CVS) criteria for sentinel lymph node dissection in uterine cancer. Assessing these CVS will help standardise the evaluation of surgical quality, improve the precision of sentinel lymph node identification, and lead to better patient outcomes.

Methods

This international multi-centre observational prospective study was conducted from April to September 2024. Surgical videos from patients with cervical and endometrial carcinoma undergoing minimally invasive sentinel lymph node dissection were collected. Three CVS criteria (lateral pararectal space, lateral paravesical space, internal iliac artery) were proposed based on the anatomical structures defined as mandatory to be identified before sentinel node dissection, according to previously published expert consensus. Three independent surgeons, blinded to each other's assessments, evaluated whether the proposed CVS criteria were identifiable in the endoscopic surgical video to establish applicability (content validity) and inter-rater agreement (reliability).

Results

Out of 80 patients enrolled, 71 cases had videos suitable for annotation, 64 (90.1%) underwent sentinel lymph node dissection for endometrial cancer, and 7 (9.9%) for cervical cancer; median age was 52 (IQR 34-71) and median body mass index was 28.8 (IQR 23.7-32.17). The lateral pararectal space was identified in 62% of videos, the lateral paravesical space in 94%, and the internal iliac artery in 32%. Inter-rater reliability was high for the lateral pararectal and paravesical spaces (Fleiss' Kappa of 0.90) and moderate for the internal iliac artery (Fleiss' Kappa of 0.73).

Conclusions

The low assessment rate of the internal iliac artery criteria should rise concerns about the possible miss of sentinel lymph nodes in the internal iliac and pre-sacral area. The assessment of such standardized safety criteria could potentially standardize the procedures thereby improving the adherence to guidelines. The introduction of the video-assessment of these criteria lays the foundation for exploring the feasibility of artificial intelligence algorithms to automatically assess and document the CVS in surgical videos.

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On a Thin Strand: The Preoperative Diagnostic Challenge of Ovarian Fibroma – A Case Series

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Background

This study examines the diagnostic difficulty in distinguishing ovarian fibromas from pedunculated subserosal uterine fibroids. Ovarian fibromas are benign stromal tumours accounting for about 4% of ovarian neoplasms and are often asymptomatic or present with nonspecific symptoms such as pelvic pain, abdominal distension or menstrual irregularities. Their solid, hypoechoic appearance on transvaginal ultrasound frequently resembles that of uterine fibroids, leading to misdiagnosis.

Due to overlapping imaging features and close anatomical proximity, accurate preoperative differentiation is challenging. This affects surgical planning, particularly when fertility preservation or oophorectomy risk is considered. Although MRI may help, its diagnostic accuracy is limited, and confirmation typically requires intraoperative assessment and histology.

By reviewing cases where ovarian fibromas were initially misdiagnosed as uterine fibroids, this study aims to highlight key clinical and radiological indicators to improve diagnostic accuracy and guide better preoperative decision-making.

Methods

This case series includes four patients with pelvic masses initially misidentified preoperatively. All underwent laparoscopic surgery at a teaching hospital in East London between 2021 and 2025. Cases were retrospectively selected based on surgical and histological records. Preoperative imaging (pelvic ultrasound and MRI) was reviewed alongside presenting symptoms to explore diagnostic discrepancies and inform surgical decision-making.

Results

All four patients were premenopausal women presenting with pelvic pain. Transvaginal ultrasound (TVUS) was performed in all cases, and three patients also underwent pelvic MRI. Preoperatively, three were diagnosed with fibroids, while one was suspected to have an ovarian endometrioma.

Gynaecology multidisciplinary team (MDT) input was obtained, and all patients underwent laparoscopic surgery. Intraoperatively, the three presumed fibroids were revealed to be ovarian fibromas, while the suspected endometrioma was identified as a pedunculated fibroid. In all cases, in-bag morcellation was used, and histopathological analysis confirmed the final diagnoses.

Conclusions

These cases highlight the diagnostic challenges of solid pelvic masses, with ovarian fibromas frequently misdiagnosed as fibroids preoperatively. Accurate differentiation remains difficult despite advanced imaging, underscoring the importance of multidisciplinary team (MDT) discussions in gynaecology for diagnosis and surgical planning.

Informed consent should address the possibility of an intraoperative change in diagnosis and procedure. When a solid ovarian mass is found, patients must be counselled on potential ovarian cystectomy, oophorectomy, and the small but significant risk of malignancy.

When fibroids are suspected, the risk of tissue dissemination should be discussed, and in-bag morcellation is advised to minimise this risk. Increased awareness among gynaecologists is essential to improve diagnostic accuracy and ensure comprehensive preoperative counselling.

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What the Surgeons need to Know: Important considerations in caesarean myomectomy

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Background

The management of fibroids encountered at caesarean section remains a therapeutic dilemma. Caesarean myomectomy is not commonly performed due to the risks of life-threatening peri-partum haemorrhage and need for peri-partum hysterectomy. We aim to evaluate the outcomes and safety of performing myomectomy during caesarean section in selected patients with large uterine fibroids, and to assess whether this approach can reduce the need for future surgical intervention and improve patient outcomes.

Methods

We present a case series of four patients who underwent caesarean myomectomy between 2023 and 2025 at Whittington Hospital, London. All patients had large symptomatic fibroids identified antenatally on ultrasound and MRI. Cases were reviewed by a tertiary foetal medicine multidisciplinary team (MDT) and deemed suitable for local delivery with potential for intrapartum myomectomy. The procedure was preoperatively planned in all cases. Intraoperative haemostatic measures included intramyometrial vasopressin, uterine tourniquet placement, Tranexamic Acid administration, cell salvage, and use of an advanced ultrasonic bipolar energy device (THUNDERBEAT) and Veriset™ haemostatic patch.

Results

Surgical indications for myomectomy included degenerated symptomatic fibroids and difficulty with uterine incision closure. Access was via Pfannenstiel and lower segment uterine incisions in all cases.

Mean patient age was 38 years (range: 33–40); parity ranged from 0 to 1, with three patients having prior caesarean deliveries. Mean BMI was 27.8 kg/m² (range: 23–33). Common antenatal symptoms included abdominal pain, pelvic pressure, and urinary and/or bowel dysfunction.

Gestational age at delivery ranged from 37+5 to 38+2 weeks. Three foetuses were cephalic, one oblique. Mean birth weight was 3.53 kg (range: 3.29–3.84 kg), with Apgar scores >9.

Fibroid specimen widths ranged from 7–13 cm, heights from 5–20 cm, with a mean dimension of 11 × 10.4 cm. Mean fibroid weight was 859.25 g (range: 176–1905 g). Estimated blood loss averaged 1.5 L (range: 1.2–1.8 L). No allogeneic transfusions were required; one patient received 200 mL of autologous blood via cell salvage. Mean operative time was 86.75 minutes (range: 74–102).

All patients followed the Enhanced Recovery After Surgery (ERAS) protocol, supporting early mobilisation and discharge. The mean hospital stay was 1.7 days. No intraoperative or postoperative complications occurred.

Conclusions

Caesarean myomectomy can be performed safely in selected patients by experienced surgical teams. Intraoperative measures such as tranexamic acid, cell salvage, advanced energy devices, uterine

tourniquet, and Veriset™ haemostatic patch can significantly reduce bleeding and mitigate the risk of hysterectomy. This approach may help prevent future surgical interventions and reduce the long-term impact of fibroids, provided there is careful patient selection and multidisciplinary planning.

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Laparoscopic unilateral pectineal suspension for apical pelvic organ prolapse: anatomical and patient-reported outcomes from a prospective cohort

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Background

Apical pelvic organ prolapse (pop) is a common and debilitating condition that affects both functional well-being and quality of life. While sacrohysteropexy remains a widely studied approach, it may not be suitable for all patients due to anatomical limitations or the need to avoid dissection near the sacral promontory. Unilateral pectineal suspension (ups) has emerged as a minimally invasive, uterus-preserving alternative that uses a lateral anchoring point with reduced operative trauma. Despite growing interest, high-quality real-world evidence on anatomical correction and functional improvement following ups is still limited.

Methods

This is a prospective observational study of 28 women with symptomatic apical prolapse (\geq stage 2 by pop-q) who underwent laparoscopic ups between February 2023 and April 2025. The technique, adapted from di Bolovis and Brucker, involves mesh-based uterine suspension to the right pectineal ligament via a retroperitoneal window. All procedures were performed by a single surgeon.

Pre- and postoperative assessments included POP-Q staging and three validated patient-reported outcome measures: the pelvic floor distress inventory (pfdi-20), the pelvic floor impact questionnaire (pfiq-7), and the pelvic organ prolapse/urinary incontinence sexual questionnaire (pisq-12). Patient satisfaction was evaluated using the 7-point patient global impression of improvement (pgi-i). Questionnaires were administered electronically via a secure, structured digital platform.

Anterior and posterior colporrhaphy were performed in 83% and 92% of patients, respectively. Bilateral salpingectomy was added in 29% of cases as an opportunistic measure for sterilisation and ovarian cancer risk reduction. The mean duration of the laparoscopic step (pectopexy) was 31 minutes, with an average estimated blood loss of 16 ml. All reported metrics refer to the laparoscopic part exclusively.

Results

The final follow-up is scheduled for July 2025, with a projected mean observation time of 12.5 months. No intraoperative or postoperative complications have occurred, and no patients have required reoperation to date. Subjective satisfaction with surgical outcomes is high. Expected results include anatomical improvement in pop-q points and significant reductions in pfdi-20 and pfiq-7 scores, with preserved or improved pisq-12 scores in sexually active women.

Conclusions

Laparoscopic ups is a safe, efficient, and versatile technique for apical pop repair, with favourable short-term anatomical and functional outcomes. Its uterus-preserving design, low morbidity, and

compatibility with vaginal reconstructive and prophylactic adnexal procedures make it a promising option in modern pelvic floor surgery. Structured digital data collection enhances the validity and reproducibility of real-world outcome assessment.

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Two Pregnancies, Two Adnexal Torsions: A Rare Case Report

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Background

Ovarian torsion is one of the few gynaecological surgical emergencies. Common symptoms of torsion include pain, nausea, vomiting, and associated abdominal or pelvic tenderness, which may vary between premenarchal and pregnant patients. Adnexal torsion during pregnancy is a rare condition, and delayed diagnosis may lead to maternal and foetal complications.

Methods

In this case report, we present a 25-year-old patient at 17 weeks of gestation (based on her last menstrual period), who presented with right lower abdominal pain, nausea, and vomiting. The patient had a history of left ovarian torsion surgery during a previous pregnancy at 11 weeks of gestation. At presentation, the patient's vital signs were stable. Laboratory findings revealed moderate leukocytosis (14,000), within normal limits of infection markers. An abdominal ultrasound performed in the emergency department by a radiologist showed stromal oedema in the right ovary, suggestive of ovarian torsion. No ovarian cyst was detected. Transabdominal ultrasound conducted by our team showed a right ovary measuring 60×35 mm, without cysts, but with stromal oedema. Doppler imaging revealed preserved vascularisation. An emergency diagnostic laparoscopy was planned.

Results

Right lower quadrant pain can raise suspicion of acute appendicitis, but no ultrasonographic evidence supported this diagnosis. Pain in torsion varies in intensity and type, and no specific pattern has been identified as diagnostic. Given the patient's pregnancy, immediate surgical decision-making may be delayed due to concerns about foetal mortality. Nausea and vomiting are common in early pregnancy and may delay diagnosis. In both pregnancies, the patient presented with these symptoms. However, during the second pregnancy, given the gestational age, hyperemesis gravidarum was ruled out. Nausea and vomiting are also common in appendicitis.

Conclusions

Adnexal torsion during pregnancy is rare. To our knowledge, no previously reported case in the literature describes torsion of different ovaries during separate pregnancies. Therefore, this may be the first reported case of its kind. When encountering ovarian torsion in a pregnant patient, the viability of the foetus and the availability of surgical resources must be considered. Despite these factors, it is crucial to recognise torsion as a gynaecological emergency and act promptly

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Emergency Cervical Cerclage in Multiple Pregnancy – Illogical, but Successful

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Background

A pregnant patient with twins at 20 weeks of gestation was admitted to the hospital due to increased vaginal discharge. A prolapsed amniotic sac was identified during a vaginal examination. Both transvaginal and transabdominal ultrasounds revealed cervical dilation to 3 cm and prolapse of the amniotic sac approximately 4 cm below the external cervical os. This pregnancy followed an IVF procedure with donor oocytes.

Methods

After extensive discussion with the patient, the decision was made to perform an emergency cervical cerclage. The cerclage was carried out using the McDonald technique. The prolapsed amniotic sac was repositioned, and an additional suture was placed at the external cervical os to close the cervical canal.

Results

The pregnancy was prolonged by 5.5 weeks. The amniotic membranes ruptured at a gestational age of 25 weeks and 3 days. Sutures were removed from the cervix, and spontaneous delivery occurred two days later. The newborns— a girl and a boy— weighed 700 g and 750 g, respectively. Both required only CPAP therapy. The infants were discharged from the hospital with their mother at the age of two months, each weighing approximately 2000 g.

Conclusions

Evidence-based medicine currently lacks data supporting the effectiveness of cervical cerclage in multiple pregnancies. However, in certain cases, decisions driven by patient wishes—even if considered unconventional—can lead to successful outcomes.

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Standardisation of Laparoscopic Entry by using a Novel device: LevaLap™ 1.0: a Prospective Multicentre Post-Marketing Clinical Follow-Up Study: Final Outcomes.

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Background

The number of laparoscopic procedures continues to grow worldwide, but so does the number of surgeons, thereby each performing fewer cases, with further dilution of experience caused by the variation of entry methods and lack of standardisation.

Although rates overall are low, up to 50% of complications occur at the time of abdominal access, which can be severe and even fatal when injuries to large vessels and the gastrointestinal tract are involved.

A device has been developed with the aim of addressing this specific challenge, the LevaLap™ 1.0 (Core Access Surgical Technologies), which facilitates the placement of the Veress insufflation needle by raising the abdominal wall using suction.

In a CT scan study, the LevaLap™ 1.0 has been shown to increase the distance between the skin and retroperitoneal vessels by >5 cm.

Objectives of the present study:

Confirm the safety and performance of the device under normal use, identify and monitor any side effects, risks or contraindications.

Methods

A prospective multicentre post-marketing cohort study in 158 laparoscopic surgical cases was performed to assess the clinical experience with LevaLap™ 1.0.

The surgeries were performed by 9 surgeons in 8 referral centres who completed a uniform CRF.

Results

- In 153 of 158 (96.8%) cases pneumoperitoneum was achieved at the first attempt (95% CI: 92.8-99.0%) and in 99.4% within the first two attempts.
- The median time required for pneumoperitoneum was 2 minutes (IQR: 2-3 min.; range: 1-6 min).
- Surgeons noted easier access (in 59.5% of cases), increased confidence (in 68.3% of cases), increased access control (in 67.1% of cases) and increased access efficiency (in 66.4% of cases).

- Surgeons reported that in 88.0% of cases the LevaLap 1.0™ positively 'did' or 'maybe did' benefit access, and that in 77.9% of cases they would recommend the use of the LevaLap 1.0™ to fellow surgeons
- Surgeons felt that a median number of 5 (range: 5-10) cases was needed to feel experienced with the device, and a median number of 10 (range: 3-20) cases was needed to determine the added value of the device
- No serious adverse events were reported and one minor device-related adverse event: a circular redness on the skin at the site of device application that resolved spontaneously.

Conclusions

- This PMCF study indicates easier, greater control, efficiency and confidence during abdominal access with LevaLap™ 1.0
- In 96.8% access was achieved at 1st attempt, and in 99.4% within the first two.
- LevaLap™ 1.0 promotes standardisation and therefore a safer abdominal access regardless of experience.

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The effect of posterior colpotomy on type of delivery after natural orifice specimen extraction: A systematic review

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Background

The purpose of this study is to validate the vaginal natural orifice transluminal endoscopic surgery (vNOTES) approach in terms of pregnancy and delivery type in reproductive-age women.

Methods

All English articles that focused on the vNOTES in relation to the following inclusion criteria were involved: women of reproductive age, patients who had a uterus, and women who want to conceive.

Results

The Non-Randomised Studies of Interventions (ROBINS-I) tool was used for quality assessment of the included studies. We included five studies out of 66159 studies. Four studies were retrospective, and one study was a case series. In the included studies, 561 patients had vNOTES and 115 patients became pregnant, 11 patients had a miscarriage, 47 women had vaginal birth, and 32 had c-sections. Fifteen c-sections were performed as per the patients' desire, and 5 were done due to prior C-sections. Fifty-eight patients needed ART, and none of the patients experienced sexual dysfunction, vaginal laceration, vaginal pain, or vaginal shortening.

Conclusions

The evidence of this study suggests that the mode of delivery in patients with a history of vNOTES procedure depends on obstetrical reasons rather than the previous vNOTES approach. This result suggests that vNOTES is a safe technique for women who want to conceive in the future.

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Learning from the Surgical Specimen: Postoperative Correlation of Preoperative Imaging in Rectosigmoid Endometriosis

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Background

Magnetic resonance imaging (MRI) and transvaginal sonography (TVS) are essential tools in the preoperative evaluation of deep infiltrating endometriosis (DIE) involving the rectosigmoid colon. While their diagnostic accuracy has been studied, a postoperative review comparing preoperative imaging with intraoperative findings and surgical specimens can provide valuable insights for improving future assessments.

Methods

To analyse lessons learned by retrospectively reviewing preoperative MRI and TVS images after surgical resection of rectosigmoid lesions in patients with DIE, and to assess how this postoperative review can inform and enhance imaging interpretation and surgical planning.

A retrospective case series of 10 patients undergoing laparoscopic rectosigmoid resection for DIE was performed. Preoperative MRI and TVS images were re-evaluated postoperatively and compared with intraoperative findings and photographic documentation of the surgical specimens. Qualitative correlation between imaging and macroscopic findings was assessed.

Results

The postoperative review identified imaging features consistent with macroscopic lesions and highlighted discrepancies between imaging interpretation and surgical reality. This process revealed potential pitfalls in preoperative imaging and suggested areas for refinement in diagnostic protocols.

Conclusions

Postoperative correlation of preoperative imaging with surgical specimens provides valuable feedback that enhances diagnostic accuracy and surgical planning in rectosigmoid DIE. This approach fosters continuous learning and multidisciplinary collaboration, ultimately benefiting patient outcomes.

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Dual Dilemma: Uncommon Recurrence of Leiomyomas in the Oesophagus and Uterus.

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Background

To examine the clinical characteristics and implications of leiomyomas, specifically those occurring as benign smooth muscle tumours in the uterus, with a focus on their high recurrence rates following both laparoscopic and open myomectomy procedures.

To identify the prevalence and features of leiomyomas as the predominant type of mesenchymal tumours in the oesophagus.

To present a detailed analysis of a case involving a patient with concurrent oesophageal and recurrent uterine leiomyomas, highlighting the complexities and challenges associated with their diagnosis and management.

Methods

A 37-year-old nulligravida presented with menorrhagia and associated pressure symptoms. She had been treated with Desogestrel for her menorrhagia. Her surgical history included a partial esophagectomy for an oesophageal tumour via a trans-diaphragmatic approach, followed by a total esophagectomy and laparoscopic gastric tubulisation six months later in 2014. Histological examination revealed a smooth muscle lesion devoid of atypia, mitotic activity, or necrosis. In addition, she underwent an open myomectomy in 2016. Her family history was significant for gastric cancer. A recent MRI of the pelvis demonstrated an enlarged uterus with a cluster of multiple fibroids distorting the uterine cavity. The largest intramural fibroid measured 7 cm. Following a multidisciplinary team discussion, which included general surgeons and gynaecologists, the patient was scheduled for an open myomectomy as a joint case.

Results

The surgical approach involved hysteroscopy to assess the uterine cavity to map the locations of the fibroids, followed by open myomectomy through a Pfannenstiel incision. Intraoperatively, extensive adhesiolysis and myomectomy were performed. Injection of Terlipressin along with tourniquet application was utilised to achieve haemostasis. Histological analysis subsequently confirmed the presence of a uterine leiomyoma

Conclusions

This case underscores three key insights:

- Surgical Innovation: Hysteroscopic mapping and adhesion management are vital for complex myomectomies.
- Collaborative Care: Multidisciplinary teams improve outcomes in rare, dual-pathology presentations.
- Future Directions: Advocates for research into recurrence mechanisms to enhance fertility-sparing outcomes and fertility-sparing techniques

- Implication: Serves as a paradigm for managing rare extragenital and uterine leiomyomas, bridging surgical expertise and patient-centred care.
- Training: Training the next generation of clinicians necessitates their active engagement in the multidisciplinary management of complex cases such as these, thereby fostering both advanced clinical learning and the development of leadership skills in the management of challenging gynaecological and extragenital pathologies.

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Transvaginal radiofrequency ablation of symptomatic uterine fibroids

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Background

Uterine fibroids are a common indication for referral to a gynaecological consultation. The surgical management of symptomatic fibroids includes a variety of procedures, such as hysterectomy, myomectomy, and uterine artery embolisation. In recent decades, a growing trend of delayed childbearing has been observed, leading to increased demand for uterus-sparing, minimally invasive treatment options. One such technique is radiofrequency ablation (RFA), which offers a non-aggressive alternative for fibroid treatment while preserving fertility potential. The objective of this study was to provide a detailed account of the clinical outcomes and complications observed in a series of four transvaginal radiofrequency ablation procedures performed for uterine fibroids.

Methods

A retrospective, descriptive study was conducted involving four patients who underwent transvaginal radiofrequency ablation for the treatment of symptomatic uterine fibroids. Patient selection was based on the presence of symptomatic fibroids, confirmed via imaging, and a preference for uterine preservation. Prior to the intervention, all patients underwent a clinical evaluation, including transvaginal ultrasound to assess the number, size, and location of fibroids. The database was established for the purpose of subsequent analysis. Descriptive statistics were used to summarise the findings.

Results

The study included four patients with a mean age of 42 years (range: 33–51 years). One patient expressed a desire for a future pregnancy. All patients presented with abnormal uterine bleeding, specifically menorrhagia, with a mean menstrual duration of 9 days at baseline.

Each patient had a single uterine fibroid. Based on the FIGO (International Federation of Gynaecology and Obstetrics) classification system, three patients had fibroids classified as FIGO type 2–5, while one patient had a fibroid classified as FIGO type 2. All patients underwent transvaginal radiofrequency ablation (RFA).

Two patients were evaluated one year post-procedure. A substantial reduction in fibroid volume was observed in one patient (96%), while the other showed a more modest reduction (16%). The remaining two patients were assessed two months following the intervention, during which an increase in fibroid volume was noted.

Despite the variability in volumetric response, all patients reported symptomatic improvement, particularly with regard to menstrual bleeding. The mean duration of menstruation decreased from 9 days pre-intervention to 4 days post-intervention.

Two patients reported experiencing mild pelvic pain on the day following the procedure, which resolved with the use of oral analgesics. No intraoperative or postoperative complications were recorded.

Conclusions

Transvaginal radiofrequency ablation can be considered a viable alternative treatment, as it does not require hospital admission, is well tolerated by patients, and is associated with a short recovery period. Future studies with larger patient populations are recommended to confirm these findings.

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Comparison of uterine manipulator types used during total laparoscopic hysterectomy, tertiary centre experience in Türkiye.

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Background

Total laparoscopic hysterectomy (TLH) is one of the most commonly used minimally invasive surgeries for gynaecological diseases today. Uterine manipulators provide anatomical visualisation by mobilising the uterus during TLH. There are many different types of uterine manipulators on the market. In this study, we aimed to find an answer to the question "Which is the ideal uterine manipulator?" by comparing the preoperative and postoperative results of uterine manipulators used during TLH.

Methods

This retrospective study included 137 patients who underwent TLH surgery due to benign gynaecological diseases (such as abnormal uterine bleeding, myoma, adenomyosis or endometriosis) at the Balıkesir Atatürk City and Research Hospital, Gynaecology and Obstetrics Clinic between May 2017 and December 2024. Uterine manipulators were selected as V Care® (ConMed Endosurgery, Utica, New York, USA), used in 55 patients in Group 1, and RUMI®II/KOH-Efficient™ (Cooper Surgical, Trumbull, CT, USA), used in 82 patients in Group 2. The groups were compared in terms of preoperative and postoperative hemogram values, operation time, uterine weight, hospitalization time, and intraoperative complications.

Results

The mean operation time in cases where V Care was used (58 ± 12.87 minutes) was found to be significantly shorter than in cases where RUMI was used (76 ± 15.43) ($p < 0.05$). No significant difference was observed between the groups in terms of preoperative-postoperative hemogram values, uterine weight, and hospitalisation time. The intraoperative complication was higher with the V Care manipulator, which had a higher risk of uterine rupture. However, no organ injury (bowel, bladder or ureter) occurred in any patient in this group due to uterine rupture.

Conclusions

The ideal uterine manipulator should be an instrument that allows for quick and easy intrauterine placement, is inexpensive and easily available, and allows the operator to manipulate the uterus without positional difficulties. Although some advanced laparoscopic surgeons can perform surgery without using a uterine manipulator, beginning or intermediate surgeons may consider the effect of the type of uterine manipulator on operative time when selecting a uterine manipulator.

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A Rare Case of Dual Appendiceal Pathology: Low-Grade Appendiceal Mucinous Neoplasm (LAMN) and Neuroendocrine Tumour (NET)

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Background

To describe an unusual case of a ruptured appendiceal mucocoele with synchronous low-grade appendiceal mucinous neoplasm (LAMN) and well-differentiated neuroendocrine tumour (NET), presenting as unexplained ascites in a young female.

Methods

A middle-aged woman presented to the gynaecology clinic with right iliac fossa pain and had free fluid in the pelvis on Ultrasound imaging. To further characterise these findings, an MRI pelvis and abdomen was performed, which demonstrated an unusually large volume of loculated free fluid within the pelvis and a cystic mass of the appendix. A CT thorax, abdomen, and pelvis was then carried out, confirming a considerable volume of ascites in this young patient and no other masses. Tumour markers were all normal except that CA-125 was raised at 55 ku/l (normal <35) and lactate dehydrogenase (LDH) was slightly elevated at 239 u/l (normal range 125–20). Given the unusual presentation, the case was discussed at the Gynaecology Multidisciplinary Team (MDT) meeting, which concluded to proceed with a diagnostic laparoscopy with the plan for peritoneal cytology, omental biopsy, peritoneal biopsy, appendicectomy, and, if necessary, ovarian cystectomy or salpingo-oophorectomy.

Results

During the diagnostic laparoscopy, a ruptured appendiceal mucocoele with mucous discharge was identified. The uterus, tubes, and ovaries appeared normal. Approximately 22ml of cloudy, pale-yellow fluid was drained from the peritoneal cavity, and peritoneal washings, omental and peritoneal biopsies, and an appendicectomy were performed. Histopathological examination revealed:

- Peritoneal washings: Benign, paucicellular fluid with no mucin detected.
- Omental and peritoneal biopsies: Normal.
- Appendix: Two coexisting pathologies—a well-differentiated G1 NET (15 mm, minimal extramural perineural invasion) and LAMN with extension of acellular mucin onto the peritonealised surface. No adenocarcinoma invasion.

Conclusions

This case underscores the extreme rarity of synchronous LAMN and appendiceal NET, two distinct pathologies each with an incidence of around 0.2–0.3% and 0.3–0.5% in appendectomy specimens, respectively. The coexistence of these tumours is exceedingly rare, with only a handful of documented cases in the literature.

In this case, the Peritoneal MDT concluded that the presence of acellular mucin in the peritoneal cavity supported the diagnosis of Pseudomyxoma Peritonei (PMP). LAMNs are well known for their potential to cause PMP even without overt malignant invasion, whereas appendiceal NETs typically have an indolent course and excellent prognosis if fully excised. Given the complexity of PMP

management, the patient was referred to a specialist peritoneal centre. This highlights the importance of meticulous histopathological evaluation and a multidisciplinary approach to ensure accurate diagnosis, effective treatment, and long-term surveillance in these rare dual pathologies.

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Improving Minimal Access Rates and Reducing The Length Of Stay: A Retrospective Audit

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Background

This audit aimed to evaluate the surgical approach to benign hysterectomy at University Hospital Lewisham (UHL), with the goal of identifying opportunities to increase rates of minimal access surgery (MAS). Laparoscopic hysterectomy is associated with lower peri-operative complication rates, reduced length of stay and faster recovery compared to abdominal hysterectomy. Secondary aims included analysing case selection, identifying barriers to day-case discharge, and assessing perioperative outcomes including length of stay (LOS) and complications.

Methods

A retrospective review was conducted of 100 consecutive benign hysterectomies performed by consultants at UHL between November 2023 and November 2024. Patients with confirmed or suspected malignancy, including atypical hyperplasia, were excluded. Data were extracted from electronic health records.

Results

Of the 100 patients, 56% underwent abdominal hysterectomy, 33% total laparoscopic hysterectomy (TLH), 6% vaginal hysterectomy (VH), and 5% laparoscopic-assisted vaginal hysterectomy (LAVH). MAS was achieved in 44% of cases, below the national benchmark of 77.7% recommended by the UK's Getting It Right First Time (GIRFT) initiative - a quality improvement programme promoting standardised surgical care. MAS was more commonly performed when uterine size was ≤ 16 weeks; 64% of abdominal procedures involved uterine size >16 weeks. Fibroids were the primary indication in 46% of cases, with the majority managed abdominally. Among TLH patients, intraoperative complications occurred in 3% (blood loss of 1L), with postoperative complications in 12% (two pelvic haematomas, one seroma, one vesicovaginal fistula). Median LOS for TLH was 1.4 days, with only one day-case. The most frequent cause of delayed discharge was postoperative pain, accounting for 51% of cases.

Conclusions

This audit highlights both the challenges and opportunities of delivering high-quality MAS in a diverse population with a high prevalence of fibroids. UHL is actively addressing barriers to MAS uptake through service redesign, enhanced recovery implementation, and investment in laparoscopic equipment (such as a morcellator). Ongoing multidisciplinary efforts aim to optimise case selection, streamline perioperative pathways, and improve equitable access to MAS

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Frozen pelvis in an adolescent: a diagnostic challenge between gastrointestinal and gynaecological pathology

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Background

To describe the complex surgical management of a frozen pelvis in an adolescent female, detailing escalation from percutaneous drainage, through laparoscopy, to laparotomy and the role of multidisciplinary input. This case underscores the diagnostic challenge, where gastrointestinal pathology — ultimately chronic appendicitis — mimicked gynaecological disease in a patient with no history of sexual activity.

Methods

Data were retrospectively extracted from electronic records, including operative notes, imaging, histopathology, and microbiology. Intraoperative images from laparoscopy and laparotomy were reviewed. Postoperative outcomes were corroborated through multidisciplinary discussions.

Results

A 17-year-old female presented with a one-year history of lower abdominal pain, lethargy, vomiting, and intermittent diarrhoea. Menstruation was regular; she was not sexually active. Initial primary care included multiple empirical antibiotics for presumed urinary tract infections, despite negative cultures. As symptoms worsened, pelvic imaging raised suspicion for a tubo-ovarian abscess, and she was referred to gynaecology. She underwent elective percutaneous drainage of a right tubo-ovarian abscess (120ml pus), with only partial improvement.

Evolving peritonitis and sepsis necessitated a laparoscopic procedure one month later, which revealed a frozen pelvis with dense adhesions, purulent collections in the pouch of Douglas, and a distended, adherent caecum. The appendix was not visualised. Adhesiolysis and washout were performed, with 500ml of pus evacuated and drains inserted. Isolated growth of *Streptococcus constellatus* suggested a gastrointestinal origin.

Despite initial drainage, she deteriorated and underwent exploratory laparotomy three days later. Findings included 1.5L of haemoperitoneum, widespread bowel and omental adhesions, multiple pelvic and interbowel abscesses, and right iliac fossa necrosis. The procedure included extensive adhesiolysis, drainage, debridement, and completion appendicectomy. Histology confirmed necrotic, inflamed abscess capsules without malignancy. Cultures revealed *Streptococcus constellatus*, *Escherichia coli*, and *Bacteroides fragilis*.

Following source control, she required intensive care and tailored antibiotics, after which she made a gradual recovery. Follow-up magnetic resonance imaging showed an involuted right tubo-ovarian abscess, fascial thickening, and small bowel tethering consistent with adhesions, but no significant residual collection.

A multidisciplinary team review concluded the findings were consistent with chronic appendicitis and spontaneous perforation, rather than primary gynaecological pathology. She remains under follow-up with gynaecology, general surgery and tertiary adolescent gastroenterology.

Conclusions

Chronic appendicitis in adolescents can present with non-specific symptoms and mimic urinary or gynaecological pathology. This case highlights the surgical complexity of a frozen pelvis and the limitations of laparoscopy in the presence of dense adhesions. Once perforation occurs, the appendix may disintegrate or become so embedded within adhesions that it is no longer identifiable or retrievable during surgery. Multidisciplinary surgical planning and staged operative management are crucial in such high-risk adolescent cases to optimise outcomes and preserve pelvic anatomy. This case underscores the importance of maintaining a broad differential diagnosis and the need for early multidisciplinary escalation in the management of complex adolescent pelvic sepsis.

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Implementation of Sentinel Lymph Node Mapping in Endometrial Cancer Staging: Impact on Clinical Practice, Surgical Outcomes, and Morbidity

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Background

Surgical staging of endometrial cancer has historically been a cornerstone in therapeutic decision-making. Lymph node status is one of the most relevant prognostic factors in endometrial cancer and plays a critical role in tailoring adjuvant treatment to the individual risk of recurrence. Sentinel Lymph Node Study (SLN) has recently been considered the standard of care in the assessment of Lymph node status in Endometrial Cancer. The objective of our study is to evaluate the impact of implementing SLN mapping in the surgical staging of Endometrial Cancer at a tertiary referral centre, focusing on diagnostic performance, reduction in lymphadenectomy rates, oncological safety, and identification of factors associated with SLN detection failure.

Methods

A retrospective observational study was conducted on 141 patients who underwent surgery for Endometrial Cancer at Hospital de la Santa Creu i Sant Pau between 2018 and 2023. Patients were categorised into three groups based on the procedure performed: hysterectomy without nodal assessment, hysterectomy with selective SLN biopsy, and hysterectomy with pelvic ± para-aortic lymphadenectomy. Clinical, surgical, pathological, and survival variables were compared across groups. In the SLN subgroup, overall and bilateral detection rates were analysed, along with concordance with lymphadenectomy findings when both procedures were performed. Univariate logistic regression models were used to identify factors associated with SLN detection failure.

Results

SLN mapping was performed in 52 patients, achieving an overall detection rate of 88.5% and bilateral detection in 46.2%. In intermediate to high-risk patients, lymphadenectomy could have been avoided in 63% of hemipelvis explored. Among 20 patients who underwent both SLN biopsy and pelvic lymphadenectomy, sensitivity was 75.0% and negative predictive value was 90.0%. Compared to lymphadenectomy, SLN biopsy was associated with shorter operative time, reduced blood loss, and shorter hospital stay. Non-endometrioid histology (OR: 9.2; $p = 0.044$) and high tumour grade (OR: 4.3; $p = 0.028$) were significantly associated with SLN detection failure.

Conclusions

The implementation of SLN mapping in Endometrial Cancer staging is a safe and effective technique that reduces the need for systematic lymphadenectomy without compromising diagnostic accuracy or oncological safety. These findings support its routine use in experienced centres following validated algorithms and incorporating ultrastaging.

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An evaluation of Web-based versus standard Information for same-day laparoscopic Hysterectomy (WISH): A randomised controlled trial

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Background

Our objective is to evaluate the potential efficacy of an additional online, patient education resource for Same Day Discharge Laparoscopic Hysterectomy (SDD LH) compared to standard information resources alone.

Methods

A pilot randomised controlled trial was conducted to test the feasibility of running a full-scale trial and evaluate the potential efficacy of a novel, online patient education resource in achieving SDD following LH. Participating women were randomised to have access to the supplementary online educational resource (mydaycasehysterectomy.com) or to receive standard, written pre-operative information. Feasibility outcomes included the proportion of eligible patients based, the number of eligible participants screened and meeting the inclusion criteria and the proportion of eligible patients agreeing to randomisation and adherence to the trial interventions/follow-up. The primary clinical outcome was compliance with SDD, and secondary outcomes included utility of pre-operative information and satisfaction (six-point Likert scales), acceptability (5-point Likert scale) and quality of life (EuroQol VAS) associated with SDD LH measured at 6 weeks post-surgery and time to resume usual activities (PROMIS-SF) censored after 12 weeks

Results

60 women were recruited over 12 months (01/03/2024 to 01/03/2025). 2/30 (6.7%) women did not access the educational website, citing technical difficulties or forgetting to do so. 97/132 (73.5%) of patients listed for LH were eligible for SDDTLH, 60/97 (62%) of these met the inclusion criteria and (100%) agreed to randomisation. All patients adhered to the trial interventions, and 58/60 (97%) completed follow-up.

Baseline characteristics, including age, BMI and relevant gynaecological history, were comparable between groups ($p > 0.05$). Surgical indication differed with a higher proportion of patients undergoing surgery for abnormal uterine bleeding in the intervention group ($P < 0.05$). Same day discharge was achieved in 23/30 (77%) women of received online information vs. 17/30 (57%) receiving standard information (RR 0.6, 95% CI 0.3 – 1.3; $p > 0.05$). Satisfaction with pre-operative information (86% vs 97%) and with overall care (89% vs 93%) was comparable / sig different ($p > 0.05$) between groups. No significant differences were observed in generic health-related quality of life post-hysterectomy between the access and no access groups (mean (SD) 3.41 (1.47) vs. 3.89 (1.42); $p > 0.05$). All 29 women randomised and accessing the educational website would recommend its use for future patients; 27 rated it “totally understandable” and two as “generally understandable”. No difference in time to resumption of usual activities was found (26.2 [IQR, 9.5]) at 6 weeks vs. 12 weeks (26.1 [IQR, 8.4]) for intervention and control groups, respectively

Conclusions

Conduct of a full-scale RCT evaluating bespoke, online patient educational information about SDD LH is feasible. Provision of such web-based information prior to surgery appears to be acceptable and useful to women and may optimise compliance with SDD as well as enhance patient satisfaction with care.

Operative Hysteroscopy and patient satisfaction Survey

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Background

Operative hysteroscopy is a key minimally invasive technique used to manage intrauterine pathology, including Myosure polypectomy, fibroids morcellation, septa and adhesions management. While it is generally well-tolerated and effective, understanding the patient experience is essential for quality improvement. This study aimed to assess patient satisfaction following operative hysteroscopy using a standardised questionnaire developed by the British Society for Gynaecological Endoscopy (BSGE) for the outpatient service

Methods

A prospective patient satisfaction survey was conducted among individuals undergoing operative hysteroscopy in the outpatient gynaecology unit at East Sussex NHS Trust (ESHT). The BSGE-based questionnaire was distributed post-procedure and covered domains including pre-procedure information, intra-procedural experience, pain management, communication with staff, and overall satisfaction. Survey responses were anonymised and analysed using descriptive statistics alongside thematic analysis of qualitative free-text feedback

Results

Out of 35 patients approached, 35 completed the survey (response rate: 100%). Overall satisfaction was high, with the majority of patients rating their experience as "good" or "excellent." Most patients felt well-informed prior to the procedure and found staff communication to be supportive and clear. A small percentage reported moderate to severe discomfort during the procedure, highlighting variability in pain experience. Thematic analysis of comments identified key positives such as staff professionalism, efficiency of care and some areas for improvement, particularly pain control, clarity of pre-procedure expectations.

Conclusions

Using a well-structured survey from BSGE as the patient satisfaction questionnaire demonstrates high levels of satisfaction with our outpatient operative hysteroscopy, particularly regarding staff interaction and pre-operative communication. The findings reflected a well-delivered and patient-centred care at ESHT.

It also supported continuing use of standardised feedback tools and suggested targeted improvements in peri-procedural pain management to further enhance the patient experience. Listening to patient feedback remains central to maintaining and refining the quality of our outpatient gynaecology services

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Robotic isthmocoele resection-repair: a standardised approach in a high-volume centre

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Background

Robotic-assisted surgery (RAS) has the potential to overcome challenges seen in traditional straight-stick laparoscopic isthmocoele resection-repair (Caesarean niche repair). The benefit of a wristed instrument and a magnified 3D HD view to delineate the boundaries of the niche, preserving healthy myometrial tissue, could reduce surgical morbidity and operative duration.

Methods

We present our standardised approach to robotic isthmocoele resection-repair in our high-volume robotic gynaecology centre. The da Vinci XI Surgical System (Intuitive Surgical, Sunnyvale CA) is docked, and intravesical ICG instillation is performed employing FireFly fluorescence imaging to improve visualisation during bladder dissection off the Caesarean niche. Our approach permits near bloodless surgery and rapid postoperative recovery with satisfactory postoperative imaging appearances of the repaired niche.

Results

Robotic isthmocoele resection-repair is usually recommended in patients with a residual myometrial volume of less than 3mm and a desire for future fertility. A 2-layer closure is performed once the fibrotic tissue is excised, using a monofilament absorbable suture (2-0 monocryl) to close the deepest layer, followed by a barbed absorbable suture (Filbloc) for the outer layer.

Residual myometrial thickness is reassessed using ultrasound sonography on average 12 weeks post-operatively. Patients are reassured and advised to start trying to conceive 3-6 months post-repair.

Conclusions

Robotic-assisted isthmocoele resection-repair is a safe and efficient approach which has the potential to improve outcomes by overcoming challenges with traditional laparoscopic surgery.

From Clots to Clarity: A Case of Extensive Intrauterine Scarring Requiring Staged Endoscopic Restoration.

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Background

Severe intrauterine adhesions (Asherman's syndrome) may lead to abnormal bleeding, hematometra, and infertility. In women with prior caesarean sections, scarring can result in complete obliteration of the endometrial cavity, requiring advanced hysteroscopic intervention.

Methods

Case Presentation: A 32-year-old para 2 woman was referred with heavy, irregular periods and passage of large clots. Ultrasound revealed a thickened endometrium (51 mm) and intrauterine blood and clot collection. She had a prior caesarean delivery.

Results

Discussion:

Operative key Steps were:

Initial Diagnostic Hysteroscopy: A 2.9 mm diagnostic hysteroscope was gently introduced into the cervical canal. On entering the uterine cavity, extensive intrauterine adhesions were visualised, with dense scar tissue extending horizontally across the fundus and dividing the cavity into two non-communicating upper chambers.

Cervical Dilatation: The cervical canal was gradually dilated using Hegar dilators up to size 9 to allow passage of the operative hysteroscope (resectoscope).

Switch to Resectoscope: A 9 mm bipolar resectoscope fitted with a Collins knife electrode was introduced. Normal saline was used as the distension medium, with continuous inflow and outflow for clear visualisation.

Ultrasound Guidance Initiated: Due to the extensive adhesions and limited cavity space, intraoperative transabdominal ultrasound guidance was employed to avoid uterine perforation and ensure precise dissection.

Adhesiolysis of Dense Scar Tissue: Stepwise resection of the thick fibrous bands was carried out using the Collins knife in a controlled fashion. The scar tissue dividing the cavity at the fundal level was carefully excised, restoring continuity between the upper compartments.

Cavity Restoration: Progressive cavity expansion was achieved, and a near-complete single uterine cavity was visualised. However, due to the duration of the procedure and increasing fluid deficit (exceeding institutional safety thresholds), the surgery was concluded before complete visualisation of the tubal ostia.

Post-procedure Assessment: Haemostasis was confirmed. No active bleeding was observed. The distension fluid volume used was documented, and the patient was transferred to recovery in stable condition.

Postoperative Planning: Given the incomplete restoration, a second-look hysteroscopy was planned for further adhesiolysis and cavity shaping. The case will be reviewed in the next departmental multi-disciplinary meeting.

Conclusions

This case highlights the complexity and precision required in managing severe intrauterine adhesions, particularly in women with a history of caesarean section and symptoms suggestive of heavy bleeding. The presence of dense scar tissue dividing the uterine cavity into separate chambers poses significant challenges, both in diagnosis and treatment. Hysteroscopic adhesiolysis under ultrasound guidance remains the gold standard approach, allowing direct visualization and careful resection of scar tissue to restore normal cavity anatomy while minimizing the risk of uterine perforation. Although the initial procedure was incomplete due to fluid deficit limitations, a staged approach with planned second-look hysteroscopy is a safe and effective strategy. With careful planning and follow-up, even severely scarred cavities can be successfully reconstructed.

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Silent Giants: Laparoscopic Management of Bilateral Giant Ovarian Cysts in an Asymptomatic Postnatal Patient.

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Background

Large bilateral ovarian cysts in the postnatal period are rare and can be discovered incidentally during pregnancy surveillance. While often asymptomatic, their size, complexity, and potential complications may necessitate surgical intervention. We present the case of a 32-year-old woman, three months postnatal, found to have bilateral large adnexal masses with mixed pathology—managed electively via laparoscopic right salpingo-oophorectomy and left ovarian dermoid cystectomy.

Methods

Case Presentation: A 32-year-old Para 1 woman was noted antenatally to have bilateral adnexal masses:

- **Right ovary:** 16 cm multilocular cyst consisting of a simple cyst, dermoid, and mucinous components.
- **Left ovary:** 8 cm dermoid cyst. She remained asymptomatic and was booked for elective laparoscopic bilateral ovarian cyst management.

Results

Discussion:

Key operative Steps were:

1. **Entry:** Pneumoperitoneum was established using a Verres needle at Umbilical point, with intra-abdominal pressure maintained at 20 mmHg. A 10 mm supraumbilical trocar was inserted for the laparoscope, followed by the placement of three 5 mm accessory ports under direct vision in the lower abdomen for optimal triangulation.
2. **Initial Assessment:** Diagnostic laparoscopy revealed a markedly enlarged right ovary measuring approximately 16 cm, comprising three distinct cystic components—simple, mucinous, and dermoid. The right fallopian tube was stretched tautly over the mass. The left ovary contained an 8 cm dermoid cyst; the left tube appeared morphologically normal.
3. **Mobilisation of the Right Adnexa:** The right adnexal mass was carefully mobilised from surrounding structures. The infundibulopelvic ligament and utero-ovarian ligament were meticulously skeletonised to allow safe adnexal resection.
4. **Right Salpingo-Oophorectomy:** The infundibulopelvic ligament, utero-ovarian ligament, and fallopian tube were coagulated and divided using a combination of bipolar and harmonic

energy devices. The right ovary and tube were excised en bloc, ensuring minimal manipulation to avoid cyst rupture.

5. **Left Ovarian Cyst Dissection:** Attention was turned to the left side. A precise cortical incision was made over the dermoid cyst. Blunt and sharp dissection techniques were used to enucleate the dermoid while preserving healthy ovarian parenchyma.
6. **Ovarian Tissue Preservation/Haemostasis:** The ovarian bed was inspected, and meticulous haemostasis was achieved using bipolar energy. The ovarian capsule was reapproximated where feasible to optimise tissue conservation.
7. **Specimen Containment:** Both the right adnexal specimen and left dermoid cyst were placed in an EndoBag to prevent intraperitoneal contamination.
8. **Specimen Retrieval:** The suprapubic 5 mm port site was extended to approximately 3 cm to facilitate atraumatic specimen extraction while preserving cosmesis.
9. **Peritoneal Toilet:** Copious peritoneal lavage was performed. No spillage of cyst contents was noted intraoperatively.
10. A thorough inspection confirmed haemostasis. All instruments were removed under vision, ports were desufflated, and port sites were closed appropriately.

Conclusions

This case highlights the feasibility and safety of laparoscopic management of large, asymptomatic bilateral ovarian cysts in the postnatal period. Preoperative imaging, careful intraoperative strategy, and tissue-preserving techniques are key. Minimally invasive surgery enabled effective treatment with excellent cosmetic and clinical outcomes.

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A Tale of Two Surgeries: Multimodal Minimal Access Management of Pelvic Abscess Following Complex Laparoscopic Excision of Deep Endometriosis

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Background

Objectives : To highlight the importance of early identification and management of postoperative pelvic abscess in patients undergoing complex laparoscopic surgery for severe deep endometriosis, and to demonstrate how a multimodal minimal access surgical approach can optimise outcomes.

Methods

Case presentation

We present the case of a 45-year-old woman with a BMI of 42 who underwent laparoscopic excision of severe deep endometriosis, bilateral ovarian cystectomy, and myomectomy.

The ENZIAN score was P2, RO2, LO2, TL3, TR3, A3, BL2, BR2. The procedure was uneventful, though the excision of a deeply infiltrating rectovaginal nodule left the posterior vaginal wall thin but intact.

Postoperative recovery was initially unremarkable apart from self-limited diarrhoea on day 3, and she was discharged on day 4. However, on postoperative day 7, she presented to the Emergency Department with acute abdominal pain, confusion (initially attributed to her underlying schizophrenia), and copious greenish vaginal discharge. She remained hemodynamically stable, afebrile, with a lactate of 0.9 mmol/L and a base excess of 2.4 mmol/L. However, inflammatory markers were markedly elevated (CRP 240, WBC 18.3), and CT imaging demonstrated a 12 cm pelvic gas-fluid collection.

Results

Discussion (Key surgical steps)

She was promptly admitted and commenced on intravenous antibiotics. In view of the discharge and concern for endometritis or a potential fistula, a combined vaginoscopy, hysteroscopy, and laparoscopy was performed.

Vaginoscopy revealed a 15 mm defect in the posterior vaginal fornix leading directly into the abscess cavity; hysteroscopy was normal. Laparoscopy revealed a severely inflamed pelvis with dense purulent adhesions involving the uterus, bowel, ovaries, and anterior abdominal wall. There was no evidence of bowel injury. The abscess was fully drained, purulent pockets opened, and the pelvis thoroughly irrigated. A Robinson drain was placed.

Postoperatively, the patient made a steady recovery with resolution of symptoms and normalisation of inflammatory markers. She was discharged after 12 days. Culture of the abscess fluid identified *Morganella morganii*. She remains under follow-up in both the acute gynaecology and endometriosis clinics

Conclusions

This case emphasises the need for a high index of suspicion for postoperative complications following complex laparoscopic pelvic surgery, especially in patients with high BMI and altered anatomy. The unusual drainage through the vagina may have prevented septic shock but masked the severity of the underlying infection. Early diagnosis using combined minimal access techniques and prompt surgical management was critical to the favourable outcome. Although *Morganella morganii* is a recognised hospital-acquired pathogen, no specific preventive approaches currently exist.

<https://esge.covr.be/cmdocumentmanagement/conferencemanager/documents/api/getdocument/14958/cmabstms/0000181570/504f91900e97e37acf7eeced3b44f62ea02eca6df7a2ebd5f65632dd2068bb08>

Shelled in Mystery: A Cellular Angiofibroma Hiding in the Vaginal Fornix

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Background

Cellular angiofibroma is a rare, benign mesenchymal neoplasm typically found in the vulvovaginal region of middle-aged women. First described in 1997, it is characterised by spindle-shaped stromal cells, numerous small- to medium-sized vessels, and a well-circumscribed border. While usually asymptomatic, these lesions may occasionally present as painful or bleeding masses, leading to diagnostic confusion with more common entities such as Bartholin's cysts, endometriomas, or fibroids. Due to its rarity and nonspecific clinical presentation, cellular angiofibroma remains a diagnostic challenge and is often confirmed only through histopathological analysis. Surgical excision remains the definitive treatment, with excellent outcomes and low recurrence rates.

Methods

A 42-year-old woman presented with a painful, bleeding vaginal mass. Preoperative imaging suggested a right-sided endometrioma; however, clinical assessment raised the suspicion of an ectopic fibroid due to the consistency and location of the lesion. Given the persistence of her symptoms, surgical excision of the mass was undertaken under general anaesthesia.

Results

Discussion (Key Surgical Steps)

- Vaginal examination under anaesthesia confirmed a cystic 3 cm mass arising from the right lateral fornix with a broad base.
- After infiltration with local anaesthesia, a linear incision was made directly over the mass.
- The lesion was carefully dissected and shelled out, appearing macroscopically consistent with a degenerating fibroid.
- Vaginal edges were closed in two layers using Vicryl Rapide 3-0: a deep continuous locking stitch with individual ties after each bite, followed by a superficial continuous layer to ensure haemostasis. Hysteroscopy reveals normal findings.
- Haemostasis was confirmed before completing the procedure.

Histopathology revealed a benign cellular angiofibroma, a rare diagnosis with few cases reported in the vaginal fornix. The lesion's presentation with bleeding and pain, along with its unusual fornical location, mimicked more common pathologies such as ectopic fibroids or endometriomas. This case highlights the importance of maintaining a broad differential diagnosis when evaluating atypical vaginal masses. Surgical excision not only offers symptom relief but also facilitates definitive diagnosis through histopathological evaluation.

Conclusions

This case underscores the diagnostic complexity of vaginal masses and the importance of histological confirmation in atypical presentations. Cellular angiofibroma, while rare, should be considered in the differential diagnosis of well-circumscribed vaginal lesions, especially when presenting with bleeding and pain. Complete surgical excision is both diagnostic and curative, with an excellent prognosis and minimal risk of recurrence.

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The Silent Bloom: A Rare Case of Abdominal Wall Clear Cell Carcinoma Mimicking a Desmoid Tumour

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Background

Primary clear cell carcinoma of the abdominal wall is an exceedingly rare malignancy, most often associated with malignant transformation of endometriotic implants at surgical scar sites. While abdominal wall endometriosis is a known sequela of caesarean section, its transformation into carcinoma is uncommon and diagnostically challenging, frequently mimicking other soft tissue masses.

Methods

Case Presentation

A 57-year-old multiparous woman was referred to the rapid-access pelvic mass clinic with a history of a rapidly enlarging, tender infra-umbilical mass. Her past obstetric history included a caesarean section performed three decades prior. She had no known gynaecological comorbidities and denied symptoms suggestive of endometriosis.

Initial transabdominal ultrasonography revealed a 76 mm irregular, solid, and vascular mass within the anterior abdominal wall. Transvaginal sonography demonstrated an unremarkable uterus and ovaries. The lesion's echotexture and location raised suspicion for scar endometriosis; however, the irregular margins, high vascularity, and rapid progression warranted consideration of a malignant process.

Results

Discussion

Cross-sectional imaging with CT confirmed an 84 mm lobulated soft tissue mass originating from the rectus sheath, with no evidence of distant metastasis. Radiologically, a desmoid tumour was initially favoured, but core biopsy revealed a high-grade malignant neoplasm—most consistent with metastatic adenocarcinoma. Immunohistochemical profiling, though inconclusive, suggested a Müllerian origin, raising the possibility of a clear cell carcinoma arising from ovarian, endometrial, or tubal tissue.

A multidisciplinary surgical approach was undertaken, involving complete excision of the abdominal wall mass and bilateral salpingo-oophorectomy. Intraoperatively, the pelvic organs appeared grossly normal, with no evidence of adhesions or endometriotic deposits. Histopathological examination of the abdominal wall mass confirmed a FIGO grade 3 clear cell adenocarcinoma. The uterus, fallopian tubes, and ovaries were benign with no evidence of malignancy or endometriosis.

Despite the absence of histological endometriosis, the final MDT consensus considered this lesion a possible malignant transformation of occult abdominal wall endometriosis secondary to the prior caesarean section.

Conclusions

Primary clear cell carcinoma of the abdominal wall, although rare, should be considered in patients presenting with rapidly growing anterior wall masses and a history of prior gynaecological or obstetric surgery. This case underscores the importance of integrating transabdominal and transvaginal imaging modalities in pelvic mass evaluation and maintaining a broad differential diagnosis, including desmoid tumours, endometriosis-related neoplasms, and metastatic disease.

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Legacy of Trauma: Multidisciplinary Management of Massive Bilateral Tubo-Ovarian Abscesses 25 Years After Motorcycle Accident.

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Background

A 50-year-old woman with a significant surgical history stemming from a motorcycle accident 25 years ago, which required midline laparotomy and bowel resection, presented with severe sepsis. Imaging revealed large bilateral tubo-ovarian abscesses resembling tumour-like masses, complicated by hydrosalpinx and extensive pelvic adhesions. These tumour-like inflammatory masses caused significant pelvic distortion, posing a surgical challenge and raising suspicion of complex pelvic pathology.

Methods

Case Presentation

Following initial intensive care stabilisation for sepsis, the patient was found to have bilateral adnexal masses consistent with severe tubo-ovarian abscesses measuring approximately 7-8 cm each. Both ovaries were engulfed in pus-filled, necrotic tissue, closely adherent to the pelvic sidewalls and rectosigmoid colon. The extensive inflammatory tumour-like abscesses obliterated the pouch of Douglas and caused dense adhesions to the bowel and pelvic organs, necessitating a combined surgical approach.

Results

Discussion:

A joint gynaecological and colorectal surgical team performed a total abdominal hysterectomy, bilateral salpingo-oophorectomy, and comprehensive adhesiolysis via a midline infraumbilical incision. Key operative highlights included:

1. **Midline Infra-Umbilical Laparotomy:** A midline incision was made below the umbilicus to gain full access to the inflamed and adherent pelvic and abdominal structures.
1. **Extensive Adhesiolysis:** Sharp and blunt dissection were used to carefully release dense adhesions involving the small bowel, uterus, and anterior pelvis, creating space to safely proceed.
2. **Mobilisation and Drainage of Left Tubo-Ovarian Abscess:** The left tubo-ovarian abscess was dissected free from the recto-sigmoid colon and surrounding tissue, followed by controlled evacuation of pus.
3. **Dissection of Obliterated Pouch of Douglas:** Dense adhesions in the pouch of Douglas were divided digitally and sharply to re-establish pelvic anatomy.

4. **Mobilisation of Right Adnexa:** The right tubo-ovarian complex, adherent to the pelvic sidewall, uterus, and bowel, was carefully mobilised to facilitate removal.
5. **Assessment of Ovarian Viability:** Both ovaries were found severely damaged and infected, precluding preservation.
6. **Bilateral Ureterolysis:** Ureters were identified and dissected free to prevent injury during the extensive pelvic dissection.
7. **Total Abdominal Hysterectomy:** The uterus was removed after securing ligaments and vessels, in coordination with colorectal surgeons managing bowel adhesions.
8. **Vaginal Vault Closure:** The vaginal cuff was closed securely using figure-of-eight sutures to ensure haemostasis.
9. **Completion and Recovery:** The surgical field was inspected for haemostasis, no complications were noted, and the patient was transferred for postoperative care and started on hormone replacement therapy.

Conclusions

Severe bilateral tubo-ovarian abscesses can mimic tumour masses and cause profound pelvic distortion and inflammation, especially in patients with complex surgical histories. This case demonstrates that thorough preoperative planning and multidisciplinary collaboration are critical to safely manage extensive pelvic infections. Radical surgery, including total abdominal hysterectomy and bilateral salpingo-oophorectomy with adhesiolysis, is an effective curative approach for large tumour-like tubo-ovarian abscesses, ensuring infection control and restoration of pelvic anatomy.

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Pregnancy outcomes after adenomyosis resection

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Background

The association between adenomyosis and infertility has not been clearly established, however, adenomyosis may negatively affect pregnancy outcomes following assisted reproductive technology (ART). The effectiveness of adenomyosis resection in improving fertility outcomes in such patients remains a subject of debate.

Methods

We retrospectively reviewed the medical records of 21 infertile women diagnosed with adenomyosis without ovarian endometriotic cysts who underwent adenomyosis resection at our hospital between August 2014 and August 2023. Of these, the records of 12 patients with available follow-up data were analysed regarding preoperative symptoms, pregnancy history, ART history, surgical methods, and postoperative pregnancy outcomes.

Results

The median age was 39 years [range: 33–43 years]. All patients had dysmenorrhea; 10 (83.3%) had menorrhagia, and 3 (16.7%) had abnormal vaginal discharge. Four patients (33.3%) had prior pregnancies, including two second-trimester stillbirths. Five patients (41.7%) had undergone ART prior to surgery. Surgical approaches included laparoscopic surgery (n=7), laparoscopy-assisted surgery (n=2), and open surgery (n=3).

Postoperatively, all patients experienced improvement in dysmenorrhea. All underwent ART treatment, resulting in pregnancy in 7 patients (58.3%). Of these, 4 delivered live births (33.3%), and 1 was ongoing at the time of analysis. The median time to pregnancy after surgery was 12 months [range: 5–16]. Among live births, 1 was preterm (at 34 weeks 3 days) and 3 were full-term. Two patients underwent emergency caesarean section (one for premature rupture of membranes and one for labour onset). One case of placenta accreta was noted among scheduled caesarean deliveries. No uterine ruptures occurred. One patient successfully delivered a second child.

Conclusions

The efficacy of adenomyosis resection in infertile patients has yet to be definitively established, with varying postoperative pregnancy rates and outcomes reported in the literature. Even if pregnancy is achieved successfully after surgery, perinatal risks such as uterine rupture and placental abnormalities remain, so treatment decisions must be made with careful consideration.

Adenomyosis resection may be a viable fertility treatment option for infertile women with dysmenorrhea and a history of stillbirth, offering potential for live birth. However, further studies and data are needed to validate its safety and effectiveness.

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Operative time and difficult cases in vaginally assisted NOTES hysterectomy

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Background

Vaginally assisted NOTES hysterectomy (VANH) is a minimally invasive surgical approach. However, its introduction in Japan is relatively recent, and limited clinical experience may hinder accurate preoperative prediction of operative time. This study aimed to retrospectively investigate factors influencing operative time in VANH.

Methods

We retrospectively reviewed VANH procedures performed at our institution between July 2022 and March 2025. Cases involving concurrent procedures such as ovarian cystectomy or planned hybrid approaches were excluded. Operative time was log-transformed and analysed using multivariable linear regression. Independent variables included patient demographics, fibroid location, surgeon, presence of adhesions or endometriosis, and specimen weight. Statistical significance was defined as $p < 0.05$. We defined prolonged cases as those exceeding the mean log-transformed operative time by more than two standard deviations (approximately ≥ 123 minutes). Additionally, cases requiring laparoscopic assistance were evaluated separately as technically demanding cases.

Results

A total of 210 patients were included. The median age, BMI, blood loss, operative time, and specimen weight were 47 (30–72) years, 21.7 (16.3–34.4) kg/m², 30 (0–800) mL, 56.5 (22.0–171.0) minutes, and 186.5 (24.0–995.0) g, respectively. Multivariable analysis identified BMI, the presence of anterior wall or broad ligament fibroids, and specimen weight as significant predictors of operative time. Seven cases met the criteria for prolonged operative time. Compared to the overall group, these cases had a higher median BMI (23.2 kg/m² vs. 21.7 kg/m²) and specimen weight (254 g vs. 186.5 g). Among them, four cases involved fibroids ≥ 5 cm located on the anterior wall or within the broad ligament. Of the four cases requiring laparoscopic assistance, three involved laparoscopic observation via the umbilicus due to difficulty in dissecting the vesicouterine pouch. One case, complicated by endometriotic adhesions in the pouch of Douglas, required conversion to laparoscopy due to uncontrolled bleeding during vaginal wall closure. In one patient, a bladder injury occurred in the setting of prior cervical cerclage.

Conclusions

Operative time in VANH was associated with BMI, the presence of anterior wall or broad ligament fibroids, and specimen weight. In particular, fibroids ≥ 5 cm in these locations may hinder visualisation and manoeuvrability, contributing to prolonged operative time. A comprehensive risk assessment, including the evaluation of fibroid location and the presence of adhesions, is essential for planning the appropriate surgical approach.

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The binary sub-classification of the congenital cervical malformation based on clinical characteristics and surgical outcomes.

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Background

Congenital cervical malformations (CCMs) are challenging congenital anomalies, related to troublesome obstructive symptoms and poor reproductive prognosis. Hysterectomy had been the mainstay of treatment for CCMs. With advances of surgical techniques, conservative surgeries, e.g., the utero-vaginal canalization, has been widely adopted. Rock's criteria stratified CCMs into cervical agenesis, fragmentation, fibrous cord and external os obstruction based on anatomic description of the cervix. However, a concise classification indicating the clinical characteristics and surgical outcomes is still expected.

Methods

We prospectively analysed sixty-five patients with CCMs completed with vaginal atresia, surgically treated by Peking Union Medical College Hospital in the past eight years. Magnetic resonance imaging (MRI) verified the diagnosis, evaluated the sub-classification, and measured the diameter of the underdeveloped cervix and the atretic vaginal space. Pelvic endometriosis was rated by the revised American Fertility Society classification system (rAFS). Based on the MRI presentation and surgical observation, we classified the cases into two groups: the "Gourd type" and the "Apple type". The former referred to those with a well-developed cervical canal while the external os was obstructed, which led to the enlargement of the cervical canal during menstruation. While the "Apple" type referred to those with absent or underdeveloped cervical canal, including cervical agenesis, fibrous cord and fragmentation. Laparoscopic uterovaginal canalisation was attempted, while those who failed underwent hysterectomy. The demographic, anatomic characteristics and surgical outcomes were compared between the two groups.

Results

Among the CCMs cases included, 33(50.8%) cases were the "Gourd type". The "Gourd type" cases were significantly younger and earlier seeking medical treatment than the "Apple type" ($P<0.001$). The rate of completed uterine anomalies was not significantly different between the two groups ($P=0.71$). Under MRI evaluation, the cervical dilation was significantly larger in the "Gourd type" cases. Besides, the width of the atretic vaginal space was significantly wider and the length was shorter in the "Gourd type" cases ($P<0.001$). Under surgical exploration, significantly more "Gourd type" cases were observed, presented with dilation of the lower uterine segment. Additionally, severe pelvic endometriosis (scored 3/4 by rAFS) was significantly more prevalent in the "Apple type" than the "Gourd type" cases (69.2% vs. 25.9% $P<0.001$). Of note, the "Gourd type" cases had a significantly higher rate of successful uterovaginal canalisation (81.8% vs. 34.4%, $P<0.001$), while the risk of intra-operative injuries was not significantly different between the groups.

Conclusions

The results of this study indicate the heterogeneity among the CCMs cases. The cases with well-developed, enlarged cervical canal (the "Gourd type"), are associated with earlier medical treatment, milder secondary pelvic endometriosis and a higher successful rate of uterovaginal canalisation. This new sub-classification of CCMs is more concise and clinically relevant in practice, directing the choice of surgical management of CCMs cases.

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ePoster Presentations

Application of Er:YAG Laser in Patients with Vaginal Agenesis Following McIndoe Vaginoplasty

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Background

Neovaginal surgery in patients with vaginal agenesis aims to create a long-term functional vaginal canal with adequate diameter, length, and normal lubrication for sexual activity. However, poor compliance with postoperative dilator use can lead to suboptimal outcomes. In such cases, non-ablative Er:YAG laser therapy may be considered prior to reoperation. This treatment uses controlled thermal stimulation to induce neocollagenesis, enhance vascularisation, and improve mucosal thickness and elasticity. This case series evaluated the effects of non-ablative Er:YAG laser therapy following McIndoe vaginoplasty on vaginal length, wall thickness, pain, and sexual function.

Methods

Four women who had undergone McIndoe vaginoplasty received vaginal Er:YAG laser therapy after providing informed consent between January and April 2025 (Ethical approval was received). The 2940 nm Er:YAG laser was applied in two steps. Step one used smooth mode (3.3 Hz, 3.5 J/cm²) with a G-Runner circular adaptor for circumferential irradiation along the vaginal length (four shots per spot, two passes). Step two used smooth mode (1.6 Hz, 1.75 J/cm²) with a PS03 handpiece (without adaptor) to treat the introitus, vestibule, clitoris, fourchette, and periurethral areas (18 shots per spot, two passes). Each patient underwent three sessions at one-month intervals. Evaluations included the Vaginal Health Index (VHI), Visual Analogue Scale (VAS) for pain, Vaginal Maturation Index (VMI), anterior and posterior vaginal wall thickness (via transvaginal ultrasound), vaginal length, and Female Sexual Function Index (FSFI), assessed at baseline and after the third session. Patients who had undergone surgery within the past six months were excluded.

Results

Participants had a median age of 34 years (range 31–36) and a median time since vaginoplasty of 21.5 months. Median VAS scores decreased from 5.0 to 1.5, and median VHI increased from 10.5 to 16. Median anterior vaginal wall thickness increased from 1.77 mm to 2.6 mm, and median posterior vaginal wall thickness from 1.615 mm to 3.05 mm. Median vaginal length improved from 5.0 cm to 5.75 cm. These changes were not statistically significant. The VMI superficial cell ratio shifted from 68.5% to 58.5%. Median FSFI domain scores showed mild increases, most notably in desire (3.6 to 4.8), arousal (2.85 to 4.8), lubrication (3.9 to 4.2), and orgasm (3.8 to 4.4). Median satisfaction and

pain domain scores remained unchanged at 4.00 and 3.6. The total FSFI score rose from 19.95 to 24.2. However, none of these changes were statistically significant. No adverse effects were reported in any of the patients.

Conclusions

Er:YAG laser therapy may offer potential benefits after neovaginal surgery, particularly for vaginal health, pain, and structural improvements. However, further studies with larger cohorts and longer follow-up are needed to confirm its efficacy and safety.

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Multisystemic endometriosis: gastrointestinal involvement and endometriotic nodule in the appendix – a laparoscopic approach

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Background

Endometriosis is a chronic, hormone-dependent, multisystemic inflammatory disease that may affect both pelvic and extrapelvic organs. Although gastrointestinal involvement is not uncommon, appendiceal endometriosis represents a particularly rare site of deep infiltrating disease. We present the case of a 37-year-old nulligravid (g0p0) woman who was initially evaluated by general surgery for gastrointestinal symptoms, including chronic pelvic pain, constipation, and abdominal distension. Colonoscopy revealed a narrowed segment at 22 cm preventing further passage, and pelvic imaging demonstrated a 7×5 cm sigmoid mass and bilateral ovarian cystic lesions. Preoperative anti-Müllerian hormone (amh) level was 1 ng/ml, and the patient was counselled about oocyte cryopreservation. given the predominance of gastrointestinal symptoms and radiologic findings, surgical management was indicated. Laparoscopic evaluation later confirmed deep infiltrating endometriosis involving the sigmoid colon and appendix.

Methods

Pelvic ct demonstrated bilateral ovarian cystic lesions, the largest measuring 42×28 mm, suggestive of endometriomas. Additionally, a 7×5 cm mass lesion in the sigmoid colon with luminal narrowing and mesenteric extension was observed. The transverse colon diameter was measured at 5.5 cm with air-fluid levels, raising suspicion of partial obstruction. during laparoscopic surgery, dense pelvic adhesions involving the uterus, ovaries, sigmoid colon, and appendix were identified. The sigmoid mass was found to be a conglomerated endometriotic nodule encasing the bowel, causing near-total luminal obstruction. The appendix was also thickened and adherent to adjacent structures. bilateral adnexa were adherent to the posterior uterine wall and bowel loops, significantly limiting their mobility. A multidisciplinary surgical team including gynaecology and general surgery performed laparoscopic bilateral salpingectomy, ovarian cystectomy, appendectomy, and segmental sigmoid colon resection. Endometriotic lesions were observed macroscopically on the bowel surface and within the appendix. Intraoperative frozen section confirmed endometriosis.

Results

The patient recovered without intraoperative or postoperative complications. Histopathological evaluation confirmed deep infiltrating endometriosis involving the sigmoid colon and appendix. at the 1-month follow-up, the patient was symptom-free, and hormonal suppression therapy was initiated to prevent recurrence.

Conclusions

This case highlights the importance of considering multisystemic involvement in patients with chronic pelvic pain and suspected endometriosis. Although rare, appendiceal endometriosis should be part of

the differential diagnosis, especially when accompanied by bowel symptoms. a multidisciplinary surgical approach facilitates complete excision and optimal patient outcomes.

Deep pelvic endometriosis may initially present with gastrointestinal symptoms, leading patients to seek care from non-gynaecologic specialties. It should be recognized as a multisystemic condition requiring cross-disciplinary evaluation.

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Rare Müllerian Anomaly:double uterus -clinical case presentation

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Background

Mullerian duct anomalies are congenital defects of the female genital system that arise from abnormal embryological development of the Mullerian ducts. A double uterus is characterized by complete failure of the Mullerian ducts to fuse leading to separate uterine cavities. Incidence of these abnormalities to be from 0.5 to 5.0% in the general population, but in case of infertility incidence increases. Women with a double uterus are at increased risk for miscarriage, preterm birth and infertility. We present a case of recurrent spontaneous abortions which was diagnosed as double uterus.

Methods

The case of a 41-year-old patient was evaluated. She was admitted to the Gheorghe Paladi Municipal Clinical Hospital with the diagnosis: Double uterus, second infertility.

Results

This patient was admitted with 6 repetitive pregnancy loss at the 5 weeks, 6 weeks and 12 weeks, infertility in a couple for 25 years. From the patient's history, at 16 years old she underwent metroplasty. Abdominal CT scan identify double uterus and double kidney (Class U3,b, ESHRE/ESGE). The patient was counselled and taken up for laparoscopic metroplasty. Laparoscopy revealed: the omentum and intestine intimately adhered to the parietal peritoneum of the anterior abdominal wall up to the urinary bladder with involvement of the uterine fundus. Was performed adhesiolysis. Right adnexa- tube with the appearance of salpingitis, ovary Normal. Left adnexa: not viewed from the adherents account. The double uterus was visualized with 2 postprocedural fused cavities after metroplasty in the anamnesis. The incision was made in V, both cavities were opened, sutures were applied continuously with vicryl thread, haemostatic control. The post-operative period was uneventful. Laparoscopic metroplasty may be considered as a therapeutic procedure for double uterus to facilitate pregnancy.

Conclusions

This case represents complex Mullerian fusion anomalies. Laparoscopic metroplasty has been shown to be a safe procedure and with all the additional benefits of minimally invasive surgery it is certainly a viable alternative to conventional open abdominal metroplasty.

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Echoes of A Cyst: An Unusual Recurrent Presentation in a Young Female

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Background

Recurrent symptomatic large benign ovarian cysts, such as mucinous cystadenomas, present a significant challenge in young females, especially when repeated surgeries are required. This case highlights the complexities of managing such cases while preserving fertility and minimizing ovarian damage.

Methods

This report details an unusual case of a young nulliparous female who underwent three laparoscopic cystectomies for symptomatic Mucinous cystadenomas over the course of a year (2023-2024). Despite these surgeries, cyst recurrences persisted, leading to egg preservation and a subsequent left salpingo-oophorectomy after discussion with a multidisciplinary gynaecology oncology team. The patient later required two additional laparoscopic cystectomies for recurrence of cysts of similar nature on the right ovary.

Results

The most recent laparoscopic procedure took place in May last month, with a follow-up appointment scheduled in six weeks with interval pelvic ultrasound. Despite repeated surgeries, the patient continues to face management challenges, especially with one ovary removed with the potential plan for another round of fertility/egg preservation for remaining right ovary.

Conclusions

This case emphasizes the importance of considering age, parity, and the impact of ovarian removal on fertility when planning surgeries for recurrent ovarian cysts. Recurrent cysts and multiple surgeries, particularly in a young woman, raise concerns about premature menopause and its physical and mental health implications. Multidisciplinary management and individualized care are essential in navigating these complex cases

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Management of interstitial pregnancy in a bicornuate unicollis uterus: A case report

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Background

Interstitial pregnancies are rare ectopic pregnancies located in the intramural portion of the fallopian tube. They are associated with high morbidity due to their potential for late rupture and significant haemorrhage. Their diagnosis and management can be further complicated by underlying uterine anomalies such as a bicornuate uterus. This case report describes the imaging findings and laparoscopic management of an interstitial pregnancy, highlighting its diagnostic complexity.

Methods

A retrospective review of the patient's electronic and paper medical records was conducted.

Results

We present the case of a 30-year-old nulliparous woman with a known bicornuate unicollis uterus who presented at 7+6 weeks of gestation with vaginal spotting and lower abdominal pain. Transvaginal ultrasound revealed a left-sided interstitial ectopic pregnancy. Serum beta-hCG was 27,051 IU/L and progesterone 31 nmol/L.

The patient underwent diagnostic laparoscopy with left salpingectomy and wedge resection of the affected uterine horn using a hybrid energy device. Due to tissue friability during suturing, conversion to mini-laparotomy was required to achieve a secure two-layer uterine closure. Estimated blood loss was 200 mL. The patient had an uncomplicated postoperative recovery and was discharged the following day. She was advised to avoid pregnancy for six months and was referred for reproductive counselling.

Conclusions

This case highlights the challenges in managing interstitial pregnancies, especially in the presence of Müllerian anomalies such as a bicornuate uterus. Surgical management may require modification depending on intraoperative findings. Early diagnosis, appropriate surgical technique, and tailored postoperative counselling are essential for optimising reproductive outcomes.

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Laparoscopic Myomectomy for a Retroverted Gravid Uterus; Complicated by Uterine Incarceration and Glob Vesicale

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Background

A retroverted uterus is present in 15-20% of women. In pregnant women, the retroverted uterus returns to its normal position by showing cranial growth at 14-16 weeks. Uterine incarceration refers to the entrapment of the uterus in the posterior pelvis with growth toward the sacrum. An altered uterine axis may cause pelvic pain and urinary symptoms.

Methods

A 32-year-old woman who was 10 weeks pregnant presented to the emergency department due to an IVF pregnancy, pelvic pain, and urinary retention. She had a retroverted uterus and a 35-mm degenerated fibroid core, which was known prior to IVF. During the physical examination, the cervix was placed anterior on speculum examination. Ultrasound revealed that, the cervix was displaced anteriorly, and a 3.5 cm fibroid was present behind the uterus. A Foley catheter was inserted due to globe vesicale. The Foley catheter was removed once a week for three weeks, and spontaneous urination was expected. Reduction was attempted once under general anaesthesia, but globus vesicalis developed at the end of all attempts. Surgery was planned because of there was no change in the ultrasound image for three weeks

Results

The patient, who was 13 weeks pregnant, underwent diagnostic laparoscopy. Intraoperative findings revealed that the uterus had twisted to the left. Myoma originating from the left posterior wall was adherent to the mesocolon and altered the uterine axis. The adhesions were dissected and laparoscopic myomectomy was performed. The patient was discharged on postop day 2 and the pathology result was reported as adenomyosis

Conclusions

Retroverted gravid uterus may rarely result in uterine incarceration. While spontaneous resolution occurs in most patients with an expectant approach laparoscopy may be curative in a selected group of patients

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Total laparoscopic hysterectomy for cervical intraepithelial neoplasia complicated by uretero-vaginal fistula: A case report

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Background

Uretero-vaginal fistula is a known and serious complication of gynaecological surgeries. This case report describes the creation of a uretero-vaginal fistula following total laparoscopic hysterectomy (TLH) performed for the management of cervical intraepithelial neoplasia (CIN) grade 3.

Methods

A retrospective review of the patient's electronic and paper medical records was conducted.

Results

A 53-year-old postmenopausal woman with a 12-week-sized fibroid uterus and CIN3 was managed with TLH following an incomplete LLETZ. The laparoscopic procedure was uneventful, and the patient was discharged on day two postoperatively. She re-presented on day four with urinary incontinence. On speculum examination, urine leakage was noted from the vaginal vault. Imaging with CT urogram suggested a vesico-vaginal fistula; however, diagnostic cystoscopy and retrograde pyelography confirmed a left-sided uretero-vaginal fistula. The patient was initially managed with a nephrostomy and subsequently underwent successful robotic ureteric reimplantation four weeks later. She recovered fully with the resolution of symptoms.

Conclusions

Uretero-vaginal fistula is a rare but serious complication of TLH, typically presenting with delayed symptoms. In this case, the ureteric injury may have resulted from mechanical injury or thermal spread during electrocoagulation of the ovarian or uterine vessels. Distortion of pelvic anatomy due to fibroids and limited visualisation of the ureteric course likely increased the risk, and the injury went unrecognised intraoperatively.

Diagnosis typically requires a combination of imaging and endoscopy. Intraoperative cystoscopy may be considered to aid in the detection of lower urinary tract injuries. While open ureteroneocystostomy was traditionally the mainstay of treatment for uretero-vaginal fistulas, definitive minimally invasive repair is increasingly feasible through robotic or laparoscopic approaches. This case reinforces the importance of anatomical awareness, judicious energy use, and early recognition of complications in laparoscopic gynaecological surgery.

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Caesarean Myomectomy – to do or not to do?

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Background

To demonstrate the operative feasibility and multidisciplinary considerations in performing a Caesarean Myomectomy in a symptomatic patient with fibroids, and to discuss surgical planning and intraoperative strategies to minimise risk.

Methods

We present the case of a 34-year-old woman with a history of one pregnancy (P1) and a BMI of 33, who experienced recurrent admissions for pelvic pain and pressure following a previous Caesarean section and was diagnosed with fibroids. Following discussion at a tertiary FMU MDT, deemed to proceed with a planned Caesarean Myomectomy locally. Preoperative planning included informed patient consent, availability of cell salvage, advanced bipolar and ultrasonic energy devices, and use of Terlipressin and a uterine tourniquet.

The procedure commenced with a Pfannenstiel incision, followed by extensive adhesiolysis. The baby and placenta were delivered. A tourniquet was applied, and Terlipressin 20 IU was injected into the fibroid capsule. Open myomectomy was then carried out, followed by two-layer uterine closure and reconstitution of the myometrium.

Results

The procedure was completed successfully. Estimated blood loss was minimised to 1.2 litres using haemostatic measures. The uterine muscle layers were successfully reconstituted in layers to effectively close the dead space after the removal of the fibroids.

After the procedure, two fibroid specimens were sent for histological analysis. The specimens were reported as benign leiomyomas, showing hyalinisation, calcific deposits, haemorrhagic changes, and notable areas of necrosis. The patient had an uneventful recovery.

Conclusions

Although Caesarean myomectomy is often eschewed due to the risks of life threatening haemorrhage, it can be safely executed meticulously in selected patients when corroborated by thorough planning, exceptional surgical expertise, and robust intraoperative support. This case emphasises the critical role of multidisciplinary collaboration and showcases the technical strategies that can significantly improve outcomes in complex obstetric procedures.

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Ultrasound-guided myomectomy: A literature review and case series on robotic intraoperative ultrasound

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Background

Uterine fibroids (myomas) are the most prevalent benign uterine tumours, often leading to symptoms such as abnormal bleeding, pelvic pressure, pain, and reduced fertility. Myomectomy is the preferred surgical intervention to preserve fertility, especially in cases of multiple fibroids. However, detecting all fibroids intraoperatively remains challenging, particularly during minimally invasive procedures with limited tactile feedback. Intraoperative ultrasound (IOUS) has emerged as a valuable adjunct in various surgical disciplines. This narrative review and case series aim to evaluate the role of IOUS during myomectomy, specifically its ability to detect additional myomas and improve surgical outcomes.

Methods

A comprehensive literature review was conducted via the Medline database using a structured search strategy targeting studies involving IOUS during myomectomy. Inclusion criteria required the use of IOUS in gynaecologic surgeries involving fibroids, with exclusion of unrelated or non-intraoperative uses. Fourteen studies were identified. Additionally, a retrospective case series was compiled from ten patients who underwent robot-assisted myomectomy with laparoscopic IOUS at University Hospitals Leuven between January 2023 and December 2024. A drop-in ultrasound probe was used intraoperatively to identify additional fibroids, and postoperative imaging assessed surgical completeness.

Results

The literature review included studies involving transabdominal, transvaginal/transrectal, contact and laparoscopic ultrasound techniques. With IOUS, fibroid detection was significantly enhanced, with some studies also suggesting a decreased recurrence rate of symptomatic fibroids.

In our case series, IOUS using a drop-in probe during robot-assisted myomectomy enabled the detection and removal of additional myomas in 8 of 10 patients. Post-operative ultrasound imaging showed minimal residual fibroids (<2cm) in 5 of 10 patients. However, this does not indicate a failure of this surgical technique, as small fibroids without significant volume or impact on the cavity do not warrant additional incisions, thereby preserving the myometrial integrity.

Conclusions

IOUS enhances the detection of fibroids that might otherwise be overlooked during robotic-assisted myomectomy. This approach may reduce symptom recurrence and the need for reoperation, especially in complex polymyomatous cases. We present the first case series on the use of a drop-in probe during robot-assisted myomectomy. Although limited by its small size and retrospective nature, the current case series provides promising evidence that aligns with broader literature

findings. Future prospective studies with larger cohorts are warranted to validate IOUS as a standard adjunct in minimally invasive myomectomy procedures.

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Hysteroscopic Isthmoplasty: Technique and Follow-up Results

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Background

Isthmocele, also referred to as a caesarean scar defect, is a wedge-shaped myometrial discontinuity larger than 1–2 mm, with a reported incidence ranging from 24% to 70%. While some patients remain asymptomatic, others present with abnormal uterine bleeding, intermenstrual spotting, pelvic pain, secondary infertility, or obstetric complications. Surgical treatment is recommended in symptomatic cases, with hysteroscopic isthmoplasty being a minimally invasive option for selected patients. This study aimed to demonstrate the hysteroscopic technique and evaluate the clinical outcomes of treated cases.

Methods

We retrospectively analysed patients who presented with abnormal uterine bleeding and underwent hysteroscopic isthmoplasty between May 2020 and May 2025. Patients with a minimum follow-up duration of six months were included. Those with other pathologies that could explain the bleeding were excluded.

Results

A total of 70 patients were included, with a mean age of 38.29 ± 4.96 years and a mean parity of 2.29 ± 0.71 . The average residual myometrial thickness was 4.46 ± 0.95 mm, and the mean operative time was 21.06 ± 4.88 minutes. The mean follow-up duration was 21.57 ± 10.44 months. No surgical complications were observed. While 2 patients (2.86%) reported persistent pelvic pain without abnormal bleeding, and 6 patients (8.57%) experienced no improvement in their initial symptoms, the majority—62 patients (88.57%)—achieved complete resolution of their complaints.

Conclusions

Hysteroscopic isthmoplasty is a safe and effective treatment option for symptomatic isthmocele, particularly in patients with abnormal uterine bleeding and adequate residual myometrial thickness. The favourable long-term follow-up outcomes support the reliability of this minimally invasive technique.

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Incidental peritoneal endometriosis in a patient who underwent a laparoscopic Vecchietti procedure due to Mayer-Rokitansky-Küster-Hauser (MRKH) syndrome; an unanticipated entity

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Background

To report and emphasise a rare combination of Müllerian agenesis and endometriosis

Methods

The patient is a 35-year-old woman with primary amenorrhea and no history of sexual intercourse, abdominal surgery, or cyclic or non-cyclic abdominal pain. The patient had recently married and presented to our clinic with the request to be able to engage in sexual intercourse with her spouse. Physical examination, ultrasound and magnetic resonance imaging revealed a blind vagina with 1.5 centimetres depth and the absence of cervix and uterus. With the initial diagnosis of MRKH syndrome laparoscopic Vecchietti procedure was planned. During the operation, bilateral rudimentary uterus horns, a fibrotic tissue band covered by peritoneum between cardinal ligaments and multiple lesions on the pelvic peritoneal surfaces displaying gunpowder-burn appearance were observed. The lesions were excised through superficial dissection, including the fibrotic areas around.

Results

The diagnosis of specimens suspected to be peritoneal endometriotic implants during surgery was confirmed by pathological examination. During the postoperative follow-up, after the first month, total vaginal length had reached 6 centimetres. The patient was still unable to engage in sexual intercourse.

Conclusions

The relation between endometriosis and Müllerian anomalies is very heterotaxic. In light of the information that the increased incidence of endometriosis in obstructive Müllerian anomalies rather than non-obstructive anomalies and regression of endometriotic lesions after excision of rudimentary uterus tissue, the Sampson theory is surpassing other theories. As a quite rare clinic phenomenon, MRKH syndrome affects one woman in every 4500; there are only a few studies reporting endometriosis cases accompanying MRKH syndrome. In a study regarding 92 patients with MRKH syndrome; %68.4 of the patients had bilateral rudiments, and %9.7 of them had unilateral rudiments. In the context of functional endometrial tissue, it was identified in all patients with unilateral rudiments, whereas only %22 of those with bilateral rudiments. (2017, Wang et al) Given the rarity of the condition, endometriosis and potentially associated abnormalities should not be neglected in patients with MRKH syndrome.

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Laparoscopic Abdominal Cerclage - Another Option for Surgical Treatment of Cervical Insufficiency

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Background

Cervical insufficiency (CI) is a significant cause of recurrent second-trimester pregnancy loss and preterm birth. Severe cervical lacerations after birth, cervical conization, previously failed transvaginal cerclage (TVC) and some congenital anomalies can undermine the effectiveness of the standard TVC. In these cases, laparoscopic abdominal cerclage (LAC) offers a minimally invasive alternative. This study aims to evaluate our 10 years of experience in performing LAC on patients with poor obstetric history due to CI.

Methods

We conducted a retrospective cohort study that included 67 patients who underwent LAC between January 2015 and December 2024, 66 pre- and 1 postconceptional. One patient required a therapeutic LAC during her 12th week of gestation. All of the other patients with elective LAC (66) had a diagnosis of CI based on previous obstetric history and/or short or absent cervix. The surgical technique was executed in the following manner: Dissection of the vesicouterine pouch in order to locate the uterine pedicle; Tunnelling the avascular broad ligament window, lateral to the uterine vessels, using the Maryland dissecting forceps; Needle-free placement of the Mersilene® 5mm tape around the cervico-isthmus area; Tying the Mersilene® tape on the front side of the uterus; Peritonisation. Furthermore, we performed a Doppler velocimetry of the uterine arteries at the end of the procedure and on the following day. The primary outcome of the study was to observe the rate of moderate to late preterm and term births. As secondary outcomes, we assessed gestational age at delivery, surgical complications and mean intraoperative blood loss. We followed up with patients until their pregnancy outcome was determined.

Results

In all of the patients, no intraoperative complications (significant blood loss, infections or damage to nearby organs such as bladder, ureter and bowels) were recorded. Of the 67 patients, 13 pregnancies ended in abortion, 14 in preterm birth and 40 in term birth. However, these abortions were unrelated to the efficacy of LAC and were attributed instead to other maternal or foetal factors. The distribution of gestational age at delivery was as follows: 3.70% (2) occurred at <28+6 weeks, 7.41% (4) between 32–34+6 weeks, 14.82% (8) between 35–36+6 weeks and 74.07% (40) at >37 weeks. The perinatal survival rate was 98.15% (53).

Conclusions

The significant live birth rates and favourable gestational age at delivery, combined with a low complication profile, indicate that LAC should be considered a safe and effective procedure with favourable obstetric outcomes.

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From Sepsis to Source: Uncovering Retained IUDs in Abdominal Actinomyces – A Case Series

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Background

The aim of this study is to highlight the diagnostic challenges posed by abdominal actinomyces associated with retained intrauterine devices (IUDs), a rare clinical entity accounting for 20–30% of actinomyces cases. Although pelvic actinomyces is more common in long-term IUD users, abdominal involvement remains poorly recognised and underreported. This case series emphasises the importance of considering actinomyces in women presenting with abdominal sepsis and a history of chronic IUD use.

Methods

A retrospective case series of four women aged 30–68 years who presented with abdominal sepsis. All had a history of prolonged IUD use and were ultimately diagnosed with abdominal actinomyces via imaging and microbiological or histopathological confirmation.

Results

- Case 1: A 68-year-old woman presented with right lower quadrant pain, fever, and a palpable mass. CT revealed an abdominal wall collection and incidentally identified a retained copper IUD in situ for 30 years. Histology confirmed actinomyces. She responded well to IUD removal and penicillin-based therapy.
- Case 2: A 50-year-old woman presented with abdominal pain, diarrhoea, and systemic signs of sepsis. Imaging showed bilateral adnexal cysts, intra-abdominal free fluid, and features suggestive of colitis. Cross-sectional imaging also revealed a 10-year-old IUD. Exploratory surgery revealed widespread pus and a pelvic abscess. Culture confirmed Actinomyces. IUD removal and prolonged antibiotic therapy led to full recovery.
- Case 3: A 30-year-old woman presented with fever, abdominal pain, mucous rectal discharge, vaginal discharge, and systemic signs of low-grade sepsis. CT and MRI showed colitis and a left tubo-ovarian abscess. Cross-sectional imaging revealed a copper IUD in situ for 4 years. The IUD was removed and cultured positive for Actinomyces. Treatment with amoxicillin resulted in full recovery.
- Case 4: A 63-year-old woman presented with fever and a one-year history of vague abdominal pain and soft tissue abscesses. Imaging revealed multiple liver and pelvic abscesses, as well as a 20-year-old retained IUD. The IUD was removed and cultured positive for Actinomyces. All abscesses resolved following IUD removal and prolonged antibiotic therapy.

Conclusions

Abdominal actinomyces is a rare but potentially severe complication associated with prolonged intrauterine device (IUD) use, often presenting with non-specific symptoms that can mimic

malignancy or other inflammatory diseases. In women presenting with abdominal sepsis or abscesses of unclear origin, especially those with a history of long-term IUD use, clinicians should maintain a high index of suspicion for actinomyces. Early recognition is crucial, as timely removal of the IUD combined with targeted, prolonged antibiotic therapy can lead to full recovery and often obviate the need for extensive surgical intervention. Multidisciplinary team management—including input from general surgery, microbiology, and gynaecology—optimizes diagnostic accuracy and treatment outcomes, ensuring comprehensive care and minimizing morbidity. Ultimately, prompt diagnosis and coordinated care are essential to prevent invasive procedures and achieve excellent patient outcomes in this challenging clinical scenario.

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A rare case of distal vaginal atresia managed with minimally invasive vaginal reconstruction

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Background

To present a rare case of congenital distal vaginal atresia in an adolescent girl, managed successfully with a minimally invasive surgical approach combining laparoscopy and transvaginal reconstruction.

Methods

A 13-year-old girl presented with a 3–4 month history of cyclic abdominal pain and primary amenorrhea. Physical examination revealed a palpable, large pelvic mass (The upper border of the uterus is palpated 2 cm below the umbilicus). Transrectal examination suggested a hematocolpos located 2–3 cm above the hymen. Transperineal ultrasonography and pelvic MRI confirmed hematocolpos, hematometra, and a 2–3 cm segment of distal vaginal atresia. Renal and uterine anatomy were normal. A laparoscopically-assisted transvaginal dissection was performed. Under laparoscopic visualisation, the bladder and rectum were carefully dissected from the atretic vaginal segment. A transverse incision was made at the inferior border of the hematocolpos on the posterior vaginal wall, allowing drainage of 800–900 mL of thick, dark-brown content. Hysteroscopy revealed a normal uterus and cervix. Vaginal walls were anastomosed to the introitus, completing a successful minimally invasive vaginal reconstruction.

Results

Postoperative recovery was uneventful. At follow-up, the patient reported regular menstruation without pain. Vaginal patency was maintained, and no complications were observed.

Conclusions

This case highlights the efficacy and safety of combining laparoscopic and transvaginal techniques in the management of distal vaginal atresia. Minimally invasive reconstruction allows for accurate dissection, effective drainage, and restoration of a functional vaginal canal in adolescent patients.

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Evaluation of Surgical Outcomes Using Translabial Ultrasonography Following TOT and Burch Procedures: A Comparative Analysis

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Background

Recent studies investigating the aetiology of surgical failure in patients undergoing incontinence procedures have increasingly utilised translabial ultrasonography (TL-USG). In patients treated with transobturator tape (TOT), factors such as mesh displacement toward the bladder neck, bladder funnelling, and asymmetry of the mesh arms have been identified as potential contributors to failure [1,2].

Methods

This study included patients who underwent incontinence surgery at our centre in 2024. A total of 30 patients were evaluated: 22 underwent TOT procedures and 8 underwent Burch colposuspension. All patients were invited for postoperative assessment. The International Consultation on Incontinence Questionnaire - Female Lower Urinary Tract Symptoms (ICIQ-FLUTS) Long Form was administered. TL-USG was performed to assess mesh location, symmetry of mesh arms, urethral mobility, and degree of bladder descent during valsalva. Physical examinations were conducted using the POP-Q classification, and the presence of a positive stress test was recorded.

Results

Demographic parameters showed no significant differences in age or number of vaginal deliveries between the two groups (Table-1). All patients had bladder volumes between 120 and 170 cc during ultrasound evaluation. Bladder descent did not differ significantly between the groups ($p=0.875$). However, menopausal status was significantly more frequent in the TOT group (45.5%) compared to the Burch group (0%) ($p=0.029$). The change in beta angle during the valsalva demonstrated a significant difference: TOT patients showed an increase [median 10.0 (iqr: -3 to 35)], while Burch patients showed a decrease [median -8.5 (iqr: -31.3 to -1.8)] ($p=0.043$), indicating contrasting patterns of urethral mobility. Stress test positivity and bladder descent measurements did not differ significantly between the groups. Based on the ICIQ-FLUTS scores, higher incontinence scores were observed in patients with urethral hypermobility, defined as a Valsalva-induced increase in the beta angle, particularly exceeding 40 degrees. This was especially pronounced in cases where the mesh had migrated toward the bladder neck instead of remaining at the mid-urethral level. In contrast, patients who underwent Burch colposuspension exhibited a paradoxical narrowing of the beta angle during Valsalva, likely attributable to the restrictive nature of the sutures. Interestingly, incontinence scores in this group increased in proportion to the degree of angle narrowing, a trend opposite to that observed in TOT patients. Asymmetry of the mesh arms was detected in two TOT patients, both of whom reported discomfort during sexual intercourse due to the more horizontally placed arm. Despite these findings, both were continent according to their questionnaire results.

Conclusions

Translabial ultrasonography represents a promising and non-invasive modality for evaluating surgical failure following incontinence procedures. Intraoperative application may be particularly beneficial in TOT cases, allowing for real-time assessment of mesh position and arm symmetry, potentially reducing postoperative complications through immediate correction. However, further prospective studies are required to confirm its utility and support its integration into standard surgical protocols.

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Reproductive Outcomes Following Laparoscopic Salpingotomy for Tubal Ectopic Pregnancy

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Background

Tubal ectopic pregnancy threatens both maternal health and future fertility. Laparoscopic salpingotomy provides a fertility-preserving approach by removing the ectopic mass while maintaining tubal integrity.

Methods

Patients diagnosed with tubal ectopic pregnancy underwent laparoscopic salpingotomy. A longitudinal incision was made at the site of the ectopic gestation to remove the sac. Tubal patency was intraoperatively assessed using diluted methylene blue injected into the uterine cavity. In several cases, this dislodged mucous plugs occluding the fallopian tube, thus restoring patency. The tube was then sutured with fine absorbable material. Serum beta-hCG levels were monitored postoperatively until negative, and hysterosalpingography was performed after one month to assess tubal patency.

Results

Between 2022 and 2025, a total of 31 patients diagnosed with tubal ectopic pregnancy were included in the study. Among them, 6 patients presented with internal bleeding and tubal rupture, requiring salpingectomy. In the remaining 25 cases, tubal preservation was possible. Of these, 7 patients underwent the "milking" technique, and 18 underwent laparoscopic salpingotomy. In 14 of the 18 patients, postoperative hysterosalpingographic follow-up confirmed tubal patency, and all subsequently achieved normal intrauterine pregnancies and full-term spontaneous vaginal deliveries, indicating preserved fertility.

Conclusions

Laparoscopic salpingotomy with intraoperative methylene blue assessment and careful tubal repair provides excellent reproductive outcomes. Clearance of mucous plugs during surgery may further enhance tubal function and future fertility.

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Assessing Interventions to reduce blood loss during open Myomectomy for large fibroids

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Background

To assess the effectiveness, safety, and tolerability of interventions to reduce blood loss during myomectomy. We also looked at the perioperative and clinical outcomes of open myomectomy for symptomatic uterine fibroids.

Methods

This retrospective cohort study included all patients who underwent open myomectomy for uterine fibroids at the Norfolk and Norwich University Hospital between January 2020 and April 2025. Interventions used to reduce blood loss included 1. Argipressin solution prepared by mixing 20 units with 100 mL of normal saline to make a total of 100 mL is used for subcapsular injection 2. A pericervical tourniquet is applied by creating avascular windows in the broad ligament bilaterally, passing a Foleys catheter through them, and then looping it around the uterus and tying a knot 3. Tranexamic acid 1gm is given at induction. 4. Intentional perioperative haemodilution.

Data were extracted from electronic patient records, and patient demographics, operative details, perioperative management, and clinical outcomes were analysed. Key outcome measures were estimated blood loss (EBL), blood transfusion, length of hospital stay (LOS), intra and post-operative complications and patient-reported symptom relief.

Results

A total of 33 patients were identified, with a mean age of 35.9 years (SD 5.7) and a mean BMI of 28.9 kg/m² (SD 5.5). The majority were of African (45%) or White (42%) ethnicity. Most uteri measured 20–24 weeks in size, with a median of 3 fibroids per patient (range 1–31) and median largest fibroid size of 100 mm (IQR 75–150 mm). Preoperative MRI was performed in all cases. Argipressin and tourniquet were used intraoperatively, and 27% received GnRH analogues. The median EBL was 300 mL; only 18% of patients required blood transfusion. The median LOS was 3 days (IQR 2–4). There were no major complications or emergency hysterectomy perioperatively. There were no complications of argipressin. Breach in the uterine cavity occurred only in 3 cases, which was identified and repaired. Histology confirmed leiomyoma in all cases. At follow-up, 91% of patients reported improvement in symptoms. 3/33 required a caesarean section during the delivery of the first pregnancy after myomectomy.

Multivariate regression identified larger uterine size and supraumbilical incision as independent predictors of higher EBL, while tourniquet use and Pfannenstiel incision were associated with shorter hospital stay. The use of argipressin and tourniquet did reduce blood loss when adjusted for case complexity.

Conclusions

Surgical treatment of fibroids through myomectomy can be associated with life-threatening bleeding, sometimes requiring emergency blood transfusion. However, knowledge and implementation of effective bleeding-reduction techniques during myomectomy can significantly lower these risks. These interventions are also linked to high rates of symptom relief. The findings underscore the importance of thorough preoperative risk assessment and the use of perioperative strategies to minimise blood loss.

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<https://esge.covr.be/cmdocumentmanagement/conferencemanager/documents/api/getdocument/15004/cmabstms/0000225930/db3ba2500c08602cc0a9217b7a302ea82d22962419cbbf6bdd6de9c47780dcc2>

Bladder and Ureter Injuries in Gynecologic Surgeries: A 10-Year Single-Center Experience

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Background

This study evaluates bladder and ureter injuries that occurred during gynaecologic surgeries at our centre over the past 10 years, focusing on surgical approach, indication, injury type, treatment, and pathological findings.

Methods

We retrospectively reviewed gynaecologic surgeries performed between 2015 and 2025 at a tertiary care centre. The patient data was received after approval from the hospital administration. Cases of bladder and ureter injuries were analysed separately. Patient demographics, prior surgeries, surgical method, indication, injury grade, mechanism, repair type, and pathology were assessed.

Results

The mean patient age was 54.8 years. Five injuries occurred during laparotomy and one during vaginal surgery. The most common indications were pelvic mass and leiomyoma. Injuries were evenly distributed between partial and total grades. All bladder injuries were recognised intraoperatively and repaired primarily by the gynaecologist. Pathology revealed benign findings in three, malignant in two, and was unavailable in one case. Ureter injury: Mean age was 53.6 years. Three injuries occurred during laparotomy and two during laparoscopy. The most common indications were pelvic mass and leiomyoma. Most injuries affected the distal ureter (60%), with mechanisms including transection (40%), ligation (40%), and crushing (20%). Surgical repairs included uretero-ureterostomy (3 patients), nephrostomy (1), and ureteroneocystostomy (1). Pathology was benign in three, malignant in one, and unavailable in one case.

Conclusions

Bladder injuries were typically diagnosed and repaired during surgery, most often during laparotomy. Ureteral injuries, which more frequently involved the distal segment, required various reconstructive techniques and were associated with more complex surgical management. Identifying high-risk patients preoperatively and performing meticulous dissection may help reduce the incidence of urinary tract injuries in gynaecologic surgeries.

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Management of Infiltrative Endometriosis: A Retrospective Cohort Study

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Background

Deep infiltrating endometriosis (DIE) is a severe form of endometriosis that often involves pelvic organs such as the bowel, bladder, and ovaries. Bowel endometriosis, most commonly affecting the rectosigmoid colon, can cause debilitating gastrointestinal symptoms and often requires complex surgical management. Magnetic Resonance Imaging (MRI) plays a pivotal role in preoperative assessment, aiding in the identification of features suggestive of deep disease, such as bowel wall involvement and mushroom lesions, kissing endometriotic ovaries, pelvic and extra-pelvic disease.

This study aimed to retrospectively evaluate the relationship between clinical features, radiological and surgical outcomes in patients referred to the Endometriosis unit. Specific objectives included assessing the prevalence of bowel endometriosis and the surgical complexity needed, and evaluating the correlation between MRI features and the likelihood of bowel surgery.

Methods

A retrospective review was conducted on 143 patients referred to the endometriosis MDT in 2021. MRI reports and surgical records were analysed to assess the severity of endometriosis and the type of surgery performed.

Results

Of 143 patients, 82 proceeded to surgery. Radical procedures—including total laparoscopic hysterectomy (TLH), TLH with bilateral salpingo-oophorectomy (BSO), or excision of the cervical stump—were performed in 35 cases (43%), with a mean patient age of 45 years (youngest 34). Bowel involvement was confirmed in 42% of surgical cases, including adhesiolysis, rectal shaving, or segmental resection anastomosis. MRI indicated bowel disease in 46 patients, of whom 26 (56%) underwent bowel surgery. Eighteen patients had a "mushroom" lesion on MRI, with 16 (89%) receiving bowel intervention. Importantly, among patients with bowel involvement at surgery, 93% had coexisting ovarian involvement on MRI—manifesting as kissing ovaries, adherent ovaries, or endometriomas (71% with endometriomas)—suggesting a potential predictive relationship. Twelve patients had both bowel and bladder involvement on MRI, with 6 requiring ureteric stenting or reimplantation. Of all the patients who underwent surgery, 40% had a retro-cervical plaque, and 86% had either endometriosis, adenomyosis, fibroids, or a combination. Previous surgery was noted in 49 patients, 21 of whom had bowel involvement.

Conclusions

The MDT proved valuable in preoperative assessment, with specific features such as the "mushroom" lesion and ovarian involvement correlating strongly with surgical bowel intervention. These findings

support the use of MRI not only as a diagnostic tool but also as a predictor of surgical complexity and resource planning.

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Adnexal Torsion: Analysis of Pathology, Surgical Approaches, and Diagnostic Challenges in a University Hospital Cohort

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Background

Adnexal torsion is a gynaecological emergency requiring timely diagnosis and intervention to preserve ovarian function and prevent complications. As a tertiary referral centre, our institution manages a diverse patient population, including complex cases referred from surrounding hospitals. This study aims to evaluate the clinical characteristics, operative management, and pathological outcomes of adnexal torsion cases managed over a 15-year period.

Methods

A retrospective review was conducted of all patients who underwent surgery for adnexal torsion at our tertiary university hospital between 2010 and 2025. Data collection was conducted following approval from hospital administration, with the requirement that all personally identifiable information be removed from the dataset. Cases were identified by searching the surgical database using the keywords "torsion" and "torsioned mass." Demographic data, surgical approach, operative findings, imaging modalities, and histopathological diagnoses were collected and analysed. Surgical approach was categorised as laparoscopy, laparotomy, or laparotomy following failed laparoscopy. Surgical methods were classified as detorsion or salpingo-oophorectomy. The presence of rupture at presentation, utilisation of CT and ultrasonography, and Doppler vascular findings were also recorded.

Results

A total of 166 patients (mean age 37.8 ± 14.9 years, range 17–89) underwent surgery for adnexal torsion. Laparoscopic surgery was performed in 54.8% of cases, while laparotomy was utilised in 44.0%, and conversion to laparotomy occurred in 1.2%. Detorsion was performed in 50.6% of patients, and salpingo-oophorectomy in 49.4%. Rupture was identified intraoperatively in 16.9% of cases. Preoperative CT imaging was used in 47.0% and ultrasonography in 45.2%. Doppler ultrasonography demonstrated vascular flow in 52.6% of the subset of cases where it was recorded. The most common histopathological findings were torsioned ovary (35.5%), no pathological abnormality (18.7%), mature cystic teratoma (12.0%), and benign mucinous cystadenoma (4.8%). Malignant tumours were rare. No significant difference was observed in pathology distribution between surgical approaches.

Conclusions

Adnexal torsion presents across a wide age range and with varied underlying pathology, most commonly benign lesions or isolated torsion without a mass. Both laparoscopic and open surgical approaches are commonly employed, with nearly half of the cases requiring salpingo-oophorectomy. Timely referral to a tertiary centre enables comprehensive management of complex cases, with histopathology confirming predominantly benign aetiologies. Notably, the presence of vascular flow

on Doppler ultrasonography does not reliably exclude torsion, highlighting the limited sensitivity of this modality and the need for continued clinical vigilance. Continued emphasis on early recognition and minimally invasive intervention may further improve ovarian preservation rates and patient outcomes.

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Surgical Management of Isthmocele: A Retrospective Study on Symptom Resolution and Reproductive Outcomes

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Background

An isthmocele is defined as a myometrial discontinuity at the site of a previous caesarean section (hysterotomy). It is an increasingly recognised pathology due to the global rise in caesarean delivery rates. Although often asymptomatic, it may lead to gynaecological and obstetric complications, including abnormal uterine bleeding, chronic pelvic pain, secondary infertility, abnormal placental implantation, uterine rupture, and caesarean scar ectopic pregnancy.

Risk factors for isthmocele include a history of multiple caesarean deliveries, urgent caesarean sections performed in advanced labour, uterine retroflexion, elevated maternal body mass index, and gestational diabetes mellitus.

Treatment is indicated only in symptomatic patients and may be medical or surgical. Surgical options include hysteroscopy, laparoscopy, laparotomy, vaginal repair, or a combination of techniques.

This study aims to evaluate the effectiveness of surgical treatment in symptom resolution and reproductive outcomes.

Methods

We performed a retrospective descriptive study of patients who underwent surgical correction of isthmocele between January 2018 and December 2024 at Centro Materno-Infantil do Norte, Unidade Local de Saúde de Santo António, in Porto, Portugal. Informed consent was obtained from all participants in the study. Data collected included uterine position, number of prior caesarean sections, presenting symptoms, type of surgical procedure, symptom resolution, and pregnancy outcomes post-treatment.

Results

A total of 29 patients underwent surgical repair. Diagnosis was established through transvaginal ultrasound, in some cases complemented by sonohysterography.

The mean age was 37 years. Among the patients, 31% were overweight and 10.3% were obese. Twenty-four patients had one prior caesarean section, and five had two, with symptoms emerging only after the last surgery. A retroverted uterus was identified in 5 patients.

All patients were symptomatic: 8 reported abnormal uterine bleeding, 17 had secondary infertility, and 4 presented with dysmenorrhea and pelvic pain.

The choice of surgical technique was guided by residual myometrial thickness (RMT): ≥ 3 mm for hysteroscopic resection and < 3 mm for laparoscopic surgery. RMT ranged from 1.0 to 3.9 mm. Hysteroscopic surgery was performed in 3.4% of cases, laparoscopic surgery in 62.1%, and combined hysteroscopic-laparoscopic procedures in 34.5%. No intraoperative complications were reported.

Among the 17 patients with secondary infertility, 8 achieved pregnancy (one ongoing), including 4 through assisted reproductive techniques. Six resulted in term caesarean deliveries without complications. One patient experienced two miscarriages.

Regarding symptom resolution, 87.5% of patients with abnormal uterine bleeding and 50% of those with dysmenorrhea and pelvic pain reported improvement.

Conclusions

Surgical correction of isthmocele appears to be an effective option for managing symptoms such as abnormal uterine bleeding and secondary infertility. Overall, 55.2% of patients experienced symptom resolution. A thorough preoperative assessment, particularly evaluating residual myometrial thickness, is essential to determine the most appropriate surgical approach. Laparoscopy is particularly suitable for cases with RMT <3 mm and, when combined with hysteroscopy, enhances intraoperative localisation of the defect.

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Pregnancy outcomes after repair of isthmocele (caesarean scar) in patients with secondary infertility at a single centre and by a single clinician

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Background

With the increase in caesarean section rates in recent years, secondary problems caused by scar tissue (isthmocele) formed during caesarean incisions are affecting subsequent fertility chances. We aimed to investigate the outcomes of subsequent pregnancies following laparoscopic or hysteroscopic isthmocele repair performed to avoid the mechanical factors caused by isthmocele formation after caesarean section.

Methods

Retrospectively, between 2020 and 2024, patients who applied to the Baskent University IVF Centre due to infertility, had undergone caesarean section and had fluid detected in the uterine cavity, were recommended hysteroscopic and laparoscopic isthmus repair surgery. No other factors causing infertility were found in these patients. During these years, 26 cases treated by a single clinician and surgeon at a single centre were included in the study. Of these, 15 patients underwent hysteroscopic repair, and 11 patients underwent laparoscopic repair of the isthmocele. Following surgery, expectant management of 4–6 months was applied to give these patients a chance of spontaneous pregnancy. Those who did not achieve spontaneous pregnancy were referred for in vitro fertilisation or intrauterine insemination. The surgical success and pregnancy outcomes of these two groups were analysed through follow-up of the medical records in the subsequent months.

Results

In the hysteroscopic group, 13 out of 15 (86.7%) patients got pregnant, in the laparoscopic group, 5 out of 9 (55.6%) patients got pregnant ($p:0.11$). In the hysteroscopic group spontaneous pregnancy rate after surgery %26.7 (4/15), the assisted pregnancy rate (IVF or IUI) %73.3, in the laparoscopic group spontaneous pregnancy rate %44 (4/9), pregnancy rate of IVF %56.6. ($p:0.4$). Since the aim of surgery is to prevent fluid accumulation in the uterine cavity associated with isthmocele and increase the chances of embryo implantation, thereby increasing the success rate of pregnancy, hysteroscopy has yielded better results in this regard. After the surgery, most of the patients had no fluid in the uterine cavity, so the success of hysteroscopy was %73.3, in the laparoscopy group %36.4 ($p:0.07$). In the laparoscopy group, repairing the isthmocele may be more difficult due to the high number of births and caesarean sections than the hysteroscopy group. In the laparoscopy group, there was small bladder damage during surgery in one patient whose isthmocele was of a large volume, in the hysteroscopy group, no complications were seen.

Conclusions

Both hysteroscopic and laparoscopic isthmocele surgery appear to be successful in treating infertility. The main goal should be to reduce the caesarean section rate or minimise scar formation from the caesarean incision. However, there is still no definitive, accepted treatment method for existing scar tissue.

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Feasibility of converting planned open gynaecological procedures into robotic surgery

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Background

Despite the widespread availability of laparoscopic surgery, many gynaecological procedures are still performed via laparotomy. Compared to conventional laparoscopic surgery, robotic surgery offers enhanced dexterity, 3D visions, improved ergonomics, autonomous camera control, and a shorter learning curve. This study aimed to evaluate the feasibility of converting planned open gynaecological procedures into robotic surgery.

Methods

This was a retrospective study conducted at a single university teaching hospital, where robotic surgery (Intuitive Da Vinci Xi) was recently introduced in benign gynaecology. Consecutive women who underwent robotic gynaecological surgery from September 2024 to May 2025 by a single surgeon were eligible. Patient characteristics planned surgical routes, operative metrics, and complications were assessed. The Mann-Whitney U test was used for statistical analysis.

Results

A total of 46 robotic surgeries were performed during the study period, of which eleven were initially planned as open procedures due to the size of the uterus, fibroids, or ovarian cysts; these included 7 myomectomies, 3 hysterectomies, and 1 ovarian cystectomy. The median age and body mass index of the patients were 43 (range 26-56) and 28.7 (range 21.2-36.2), respectively. Only one case was converted to open surgery due to equipment failure with AirSeal and anaesthetic complications, as well as another instance of a superficial bowel serosal injury, which was repaired robotically using sutures. When comparing the 7 converted robotic myomectomies with the 15 open myomectomies performed during the same study period, robotic surgery was associated with a longer operative time (median 208 mins, (IQR 151-300) vs 138 mins, (IQR 106-160), $p = 0.002$) but a shorter length of hospital stay (median 1 day, (IQR 1-2) vs 2 days, (IQR 2-3), $p = 0.006$). There was no significant difference in blood loss (median 1000ml, (IQR 150-2000) vs 400ml, (IQR 200-1000), $p = 0.16$) and the weight of the fibroids (median 1073g, (IQR 303-2476) vs 656g, (IQR 277-949), $p = 0.86$).

Conclusions

Converting open gynaecological procedures to robotic surgery is feasible. Complex myomectomies performed robotically may lead to a shorter hospital stay at the cost of a longer operative time. Further study is required on the cost benefits and patient-reported outcome measures.

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What is surgery? The first structured evaluation for a unifying definition of surgery considering modern advanced concepts in minimal access techniques, anaesthesia and enhanced recovery.

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Background

The word surgery has been noticed to be increasingly used at the beginning of 1800s since the time of the Napoleonic wars. Since then, surgery has transformed dramatically with the advancement in minimal access techniques and regional anaesthesia, particularly with the adoption of enhanced recovery since 2000. The etymology of the word means 'hand work' from ancient Greek; however, current searches of the modern English dictionaries and resources did not provide a satisfactory uniform definition that covers the wide spectrum of surgical specialities, indications, applications and innovations. This is the first methodical approach to set a uniform definition of surgery and the first step in the validation process before future versions and modifications

Methods

Through a qualitative research approach, a draft definition was discussed with a philosopher using various arguments. It started with agreeing with essence of the word etymology; handwork work but moved gradually to apply it specifically to surgical practice. Then, specific questions were debated: what is a good surgery (or surgeon)? vs. what is an ideal surgery (or surgeon)? To answer this test, the teleological approach (Aristotle) vs. the theory of the forms approach (Plato) was explored. The emerging terminology was tested using the theory of the union of opposites (Anaximander, Heraclitus). A study group was formed to study the various aspects of the definition in the English language. This was done through qualitative research from 2022 to 2024, discussing with experienced consultants of different specialities, gynaecology, urology, neurosurgery, general surgery, thoracic surgery, cardiac surgery, plastic surgery, orthopaedics, anaesthesia and psychiatry. The definition was ultimately unified and tested against various indications for surgery, applications and current methods to perform surgery. It was also tested against 5 major adverse events in gynaecologic laparoscopic surgery to observe its utility.

Results

The repeated assessments of the definition consistently involve the concept of cutting through tissue layers in contrast to entering body cavities, like in diagnostic endoscopies for various organs. However, when those involved in interventional cutting are then it is considered surgery. The surgery should be a purposeful, beneficial and measured action that put the physiological condition and psychological status in consideration. The agreed definition is '**Surgery is a calculated, intentional, necessary bodily injury to the anatomy, physiology and psychological well-being to achieve a well-defined target to maintain or improve patient physical, functional and psychological status using standardised techniques and specific tools**'.

So far, it has been found that the definition is applicable to many indications and procedures and is ready to be tested through further assessments.

Conclusions

This is the first structured approach to define what surgery is, and it can be the baseline for further modification and improvements through testing it in various surgical disciplines and with potential legal and governance applications.

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Rediscovery of the anatomy of the umbilicus, understanding the infra umbilical gynaecology space and surgical applications for classification of the types of single access incisions

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Background

Single-port surgery can offer the combination of cosmesis and functionality. It is practised on less frequently than standard laparoscopy as the triangulation is more challenging to the surgeon and requires further training and careful case selection. This study aims to offer standardised approach for starting single port access, understanding the applied anatomy of the umbilicus.

Methods

The technique was practiced technique of entry was observed across 100 cases performed in Epsom Hospital from 2023 to 2024. The technique was performed by one surgeon using Gelpoint Applied advanced platform. The umbilicus is stabilised with Little Woods and everted to clarify the anatomy and get a more precise incision. Then the rectus sheath is reached and opened with an incision 0.5 to 1cm longer than the skin incision. The various types of incision were recorded, classified and coded.

Results

The non scarred umbilical area has a consistent anatomy representing the fusion of the rectus sheath and meeting points of the obliterated Lateral umbilical ligaments (umbilical arteries), Median umbilical ligament (urachus), and the round ligament (the umbilical vein). However, age, body build, and loss or gain or weight will affect the geography of the umbilicus surface anatomy. In the inferior umbilical edge, if the skin is incised vertically or horizontally at a shallow depth involving only the skin then there will a vascular space composed of the umbilical scar superiorly, the fusion of the fat and Scarps fascia posteriorly by around 2 to 3 cm and the rectus abdominis muscles and the obliterated median umbilical ligament posteriorly. If this is isolated, stabilised and divided, then it will be the quickest access to the peritoneal cavity

On performing single-site laparoscopy, it was found that the length of the of the skin incision can be divided into

- a- 2cm; which is very cosmetic
- b- 2-3cm; upper limit of cosmesis
- c- >3cm; no cosmesis gained

The skin incision design was classified into the following types

- 1- Trans umbilical vertical incision
- 2- Para umbilical vertical omega incision
- 3- Infra umbilical vertical incision
- 4- Infraumbilical horizontal omega incision

The rectus sheath incision should be only more than the length of the skin by 1cm only otherwise, it will lead to tissue stress. and it was better to extend inferiorly than posteriorly to avoid risk of supraumbilical hernia, especially in elderly and multiparous women.

The gynaecology infraumbilical space represents the most efficient access to the peritoneal cavity in the open technique or single access strategy. It is assumed that there is a similar configuration on the

superior umbilical fold, but it was not utilised for gynaecological indications.

Conclusions

Understanding the umbilical anatomy has major applications in laparoscopic surgery, and it can gain further importance with the progression of single port surgery, including robotic surgery.

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Pelvic Floor Disorders on Instagram: Who are Pelvic Floor Disorders Influencers and What are They Posting?

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Background

Women visiting urogynaecology clinics have high internet use and a desire to learn about their conditions via social media (1). The aim of our study was to analyse who are pelvic floor disorders (PFD) influencers on Instagram and what content they are posting.

Methods

We conducted a cross-sectional study in which we identified verified Instagram accounts using hashtags, which are words or phrases preceded by a pound sign (#). Hashtags are used to categorise creator's posts and make them discoverable. The following hashtags were used: #pelvicfloor, #pelvicfloorhealth, #pelvicfloortraining, #pelvichealth, #pelvicfloormuscletraining, #pelvicfloorthrapy, #urinaryincontinence, #fecalincontinence, #womenshealth, #pelvicorganprolapse, #prolapse, #postpartumprolapse, #cystocele, #rectocele, #enterocele, #urethrocele. We then identified 50 accounts with the largest number of followers. For each account, the following data was obtained: number of followers, number of posts, the owner of the account (individual/organisation), in case of individual owners, their education and whether their research work can be found in the PubMed database. The last 10 posts of each account were analysed, and the following parameters were assessed: whether the content of the post is related to PFD, whether it is an affiliate post, and the content of the post (urinary incontinence, faecal incontinence, pelvic organ prolapse, pelvic floor in pregnancy and after delivery, PFD prevention, PFD treatment). Data were analysed using SPSS Statistics Programme.

Results

Out of 50 Instagram accounts, 34 (68%) were owned by individuals and 16 (32%) by organisations. In cases of individuals, the owners were most commonly physiotherapists (69.4%), followed by fitness trainers (11.1%) and medical doctors (5.6%). There were no midwives or doulas. Of all account owners, only 6 (16.7%) were authors of articles on PFD, included in the PubMed database. The accounts had on average 105,256 followers (range 265–1,500,000) and 1,000 posts (range 85–3542). When analysing the last 10 published posts on each account, we discovered that 70.6% of posts had PFD-related content and 37 % of all posts were affiliate content. Affiliate posts were mostly promoting the products of the owner of the account (in 79.1%) and less commonly products of other companies (20.9%). Significantly higher percentage of affiliate posts was observed in posts on PFD treatment (82.1 %, $p<0.001$).

The most frequent topics of PFD-related posts were pelvic organ prolapse (17.6%), pelvic floor in pregnancy and after delivery (15.1%) and PFD treatment (8%). The least represented topic was faecal incontinence (0.6%).

Conclusions

Women can find a lot of PFD-related accounts and content on Instagram platform. The accounts are usually owned by individuals, mostly physiotherapists. However, more than one third of content are affiliate posts, and the percentage is even higher in posts on PFD treatment, which can in our opinion represent a source of bias.

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Trainees Keen, Robots Unseen: Evaluating Robotic Surgical Exposure in West Scotland O&G

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Background

Formal robotic surgery training has recently been introduced to Obstetrics and Gynaecology (O&G) in the UK. This study aimed to evaluate trainee exposure to, and perceptions of, robotic-assisted surgery (RAS) training in the West of Scotland following the launch of the new RCOG RAS Special Interest Training Module (SITM).

Methods

An anonymised online survey was distributed to 98 O&G trainees across the West of Scotland. The questionnaire gathered data on RAS exposure (e.g., observation, assistance, simulator use), awareness of the RAS SITM, perceived readiness for robotic participation, interest in further RAS training, and barriers to access. A total of 29 trainees responded (30% response rate).

Results

Of the 29 respondents, 18 (62%) reported some exposure to RAS. Twelve (28%) had observed a robotic procedure, nine (21%) had assisted, and five (12%) had used a simulator. Awareness of the SITM was relatively high (72%). However, 79% reported low confidence in assisting or performing robotic procedures, mainly due to lack of structured training. Key barriers identified were limited access to robotic systems in training hospitals, insufficient local mentorship, and absence of structured programmes. Despite these limitations, 94% expressed strong interest in acquiring robotic skills and recognised their relevance to future gynaecological practice.

Conclusions

Trainees in the West of Scotland currently face limited access to robotic surgical training, despite strong interest and awareness of the RCOG RAS SITM. Addressing the structural barriers, particularly access to mentors and robotic platforms, is essential. Incorporating robotic exposure earlier in training and establishing local structured pathways will be critical to preparing future gynaecologists for the increasing integration of RAS into clinical care.

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Diagnosis and Management of OHVIRA Syndrome: Clinical Features, Imaging Findings, and Outcomes

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Background

OHVIRA syndrome (Obstructed Hemivagina and Ipsilateral Renal Anomaly) is a rare congenital disorder characterised by uterus didelphys, obstructed hemivagina and ipsilateral renal agenesis or anomalies. Due to its variable presentation, it is often diagnosed late or remains asymptomatic, leading to potential delays in management and reproductive issues. Understanding the clinical features, diagnostic approaches, and outcomes in affected patients is essential for improving diagnosis and treatment strategies

Methods

A retrospective study was conducted at the Cruces University Hospital, analysing cases diagnosed with OHVIRA syndrome from 1999 to 2025. The study included 10 patients whose clinical characteristics, diagnostic procedures, and treatments were reviewed and compared with existing literature. Data collected comprised age at diagnosis, presenting symptoms, associated renal anomalies, imaging modalities used (ultrasound, MRI), and treatment outcomes.

Results

The median age at diagnosis was 18.2 ± 7.8 years. All the patients exhibited typical features, including uterus didelphys and hemivaginal obstruction and renal agenesis with associated renal anomalies (60%) such as remnant ureter (3) or ectopic implantations. Renal anomalies were predominantly on the left side (60%). Clinical presentation varied; some patients were asymptomatic (20%), while others experienced dysmenorrhea (60%) or infertility (20%). Diagnostic imaging primarily involved ultrasound and MRI. Surgical management was the main treatment approach, including resection of vaginal septa and drainage, often leading to symptom resolution. The study observed that postoperative pregnancies were achievable; however, most of the population studied has not yet shown gestational desire and will need to be reviewed in the future.

Conclusions

OHVIRA syndrome remains a diagnostic challenge due to its low incidence and often asymptomatic course. Early recognition through symptom recognition, physical examination, and imaging studies such as ultrasound and MRI is crucial for proper treatment. Imaging studies like ultrasound and MRI are crucial for appropriate management. Surgical intervention effectively alleviates obstructive symptoms and improves reproductive potential. Given the association with renal anomalies, comprehensive evaluation of the urinary tract is mandatory in these patients. Increased awareness among clinicians may reduce diagnostic delays, allowing for better prognosis and fertility outcomes.

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Rare But Real: Colorectal Germ Cell Dermoid - A Case-Based Review

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Background

Mature cystic teratomas are typically benign ovarian tumours; however, malignant transformation occurs in rare cases (0.17-2%), most commonly into squamous cell carcinoma. Adenocarcinoma of colorectal type arising in a monodermal teratoma is an extremely rare entity. We report the case of a 25-year-old woman undergoing fertility evaluation, in whom an incidental invasive mucinous adenocarcinoma of colorectal type was identified during workup.

Methods

On 3rd September 2024, the patient underwent laparoscopic cystectomy for a 15 cm right ovarian dermoid cyst as part of fertility assessment. The surgery was technically challenging due to the size and consistency of the lesion. Histopathology revealed an unexpected diagnosis of invasive mucinous adenocarcinoma of colorectal type arising in a monodermal teratoma (FIGO stage IC). An urgent CT of the chest, abdomen, and pelvis was requested by the multidisciplinary gynaecologic oncology team to evaluate for a primary colorectal tumour and/or metastatic disease. The CT showed no primary colorectal malignancy, evidence of distant malignancy or lymphadenopathy.

Results

Following multidisciplinary discussion, involving gynaecologic oncology and colorectal teams, a decision was made to perform a right salpingo-oophorectomy and omental biopsies. Surgery was successfully completed laparoscopically, conserving fertility as per her wishes. Following review of her final pathology in the gynae-oncology, colorectal and the supra-regional referral centre for germ cell tumours, adjuvant capecitabine and oxaliplatin, alternating with etoposide and cisplatin was recommended. Prior to initiating chemotherapy, the patient underwent oocyte cryopreservation to preserve fertility.

Conclusions

The case underscores the value of balancing oncologic safety with fertility considerations in young patients and demonstrates the variety of pathologies that can arise in a dermoid cyst. Furthermore, it is an example of MDT collaboration by working seamlessly alongside the supra-regional referral centre to enable timely diagnosis, oncologic management, and fertility preservation in a young woman with an extremely rare malignancy arising in an ovary.

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Ultrasound-Guided Transvaginal Radiofrequency Ablation of Uterine Myomas – Our experience with the first five patients

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Background

Transvaginal radiofrequency ablation (TVRFA) of uterine myomas is a novel, minimally invasive procedure for the treatment of symptomatic fibroids. It is particularly suitable for cases where operative hysteroscopy or laparoscopy is not feasible or effective. The technique is based on the application of high-frequency alternating current, which generates localised heat within the fibroid tissue, inducing coagulative necrosis and irreversible cellular death. The necrotic tissue is gradually reabsorbed, leading to a reduction in fibroid volume and improvement of associated symptoms. The aim of this study was to evaluate the outcomes of transvaginal ultrasound (US)-guided radiofrequency ablation of uterine fibroids in our initial series of five patients.

Methods

Premenopausal women with symptomatic uterine leiomyomas were enrolled in this prospective observational study. A total of five patients underwent TVRFA. The volume of each fibroid was measured preoperatively and subsequently at 1-, 3-, 6-, and 12-months post-procedure using transvaginal ultrasound.

Results

The procedure was successfully performed in all five patients, aged 36 to 49 years. Three patients underwent treatment due to infertility, one due to rapid myoma growth, and one because of anaemia caused by heavy menstrual bleeding. No significant adverse events or complications were observed during or after the procedure. Patients reported a post-procedural pain score of 1 on the visual analogue scale (VAS) and required analgesics only during the first postoperative day. Four patients had a single fibroid, while one patient had two fibroids treated. All fibroids were classified as FIGO (The International Federation of Gynaecology and Obstetrics) types 3 or 4. The mean fibroid volume reduction at one month was 39.8%, and at twelve months, the average reduction reached 90.6%. The anaemic patient reported regular menstrual bleeding and normalisation of haemoglobin levels three months after the procedure.

Conclusions

Our preliminary results suggest that transvaginal ultrasound-guided radiofrequency ablation is a safe and effective therapeutic option for the treatment of uterine fibroids. Despite the small sample size, this minimally invasive method appears promising, with a favourable safety profile and significant clinical benefits.

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Acute urinary retention in a 48-year-old woman: a rare initial presentation of metastatic gastric carcinoma masquerading as a uterine fibroid

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Background

Uterine fibroids commonly present with heavy menstrual bleeding and pelvic pressure. acute urinary retention (AUR) is a rare manifestation. Even rarer is metastatic disease mimicking fibroids. We report a case of AUR caused by a posterior uterine mass initially presumed benign, later diagnosed as metastatic gastric carcinoma.

Methods

A 47-year-old multiparous woman (P3) presented with her first episode of AUR. she reported menorrhagia, early satiety, and urinary frequency over months. No bowel symptoms or weight loss were noted. She has no significant past medical and surgical history. Examination revealed a 10–12 week-sized uterus with a posterior mass displacing the cervix anteriorly. a urinary catheter drained 800 ml.

pelvic ultrasound showed a bulky uterus with a 96 × 74 mm posterior fibroid. MRI confirmed a 7.2 × 8.1 × 3.1 cm posterior submucosal fibroid with cystic degeneration and bladder compression. focal adenomyosis was also seen. she underwent laparoscopic myomectomy, adenomyosis resection and cervical polypectomy, preserving fertility.

Histology revealed a benign cervical polyp and leiomyoma infiltrated by poorly differentiated metastatic carcinoma of gastrointestinal origin. Tumour emboli were present in adenomyosis foci. The patient was referred to local and tertiary MDTs, including a sarcoma MDT. Further workup confirmed metastatic gastric adenocarcinoma with endometrial secondaries, PD-L1 CPS2, and pMMR status. She commenced chemoradiotherapy at a tertiary centre.

Results

Metastatic uterine involvement from gastric carcinoma is exceedingly rare and may mimic benign fibroids clinically and radiologically. AUR due to uterine mass effect is uncommon but should prompt investigation for malignancy when atypical features exist. In premenopausal women, an endometrial biopsy before surgery may be helpful in diagnosing underlying malignancy or secondary involvement, guiding appropriate management. This case emphasises the necessity of histopathological evaluation in all uterine masses and multidisciplinary management for optimal outcomes.

Conclusions

this case highlights diagnostic challenges in uterine masses presenting with AUR and the importance of considering metastatic disease. Imaging may underestimate malignancy risk. multidisciplinary collaboration is essential for diagnosis and treatment planning in complex gynaecological cases

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Prospects of using radiofrequency ablation in the treatment of symptomatic uterine fibroids

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Aim

The research aims to improve the tactics of surgical treatment of women of reproductive age and in the premenopausal period with symptomatic uterine fibroids in outpatient settings using radiofrequency ablation.

Background

Uterine fibroids (UF) are one of the most common and yet understudied diseases in women. These tumours affect women mainly during their reproductive years and are diagnosed in up to 80% of women during their lifetime. Though most women with fibroids are asymptomatic, approximately 30% of them will present with severe symptoms, which can include abnormal uterine bleeding, anaemia, pelvic pain and pressure, back pain, urinary frequency, constipation, or infertility, and will require intervention. Furthermore, fibroids have been associated with poor obstetrical outcomes. The current options for symptomatic fibroid treatment include expectant, medical, and surgical management, and interventional radiology procedures. An ultrasound-guided radiofrequency ablation (RFA) is an outpatient procedure for uterine fibroids. The procedure utilises recent technological advancements in instrumentation and imaging, allowing surgeons to treat numerous fibroids of varying size and location in a minimally invasive way.

Materials / Patients

We analysed the data of 52 women of reproductive age and premenopausal age (mean age 37.4 ± 4.4 years) with symptomatic uterine fibroids and objectively confirmed heavy menstrual bleeding (≥ 150 to ≤ 450 ml), who underwent outpatient intervention of radiofrequency ablation treatment of fibroids. Among the RFA patients who conceived, the average age at ablation was 37 years old (range, 27-46 years). Most patients had between 1 and 3 myomas ablated, and myomas size ranged from <2 cm to 8.5 cm.

Methods / Results

Patients with uterine fibroids (UF) (n=52) were divided into 2 groups depending on age: reproductive age (20-45 years) and premenopausal age (45-55 years). Group I consisted of 20 patients; Group II – 30 patients, who underwent gynaecological examination, ultrasound. During examination, the size, location, quantity, and vascular supply of fibroids were determined. The main complaint of patients in Group I was pain and growth syndrome, while the main complaint in Group II was heavy menstruation (80.0% of patients). A 17.7% reduction in the size of the myomatous node was observed in the first group, compared to 23.4% in the second group of the study, 3 months after the RFA procedure. Evaluation 6 months after the procedure showed a reduction in the size of the uterine myoma by 47.5% and 58.6% of the initial size of the uterine myoma, respectively.

Discussion

RFA is effective in treating fibroids of various sizes and numbers in a single setting.

Conclusion

RFA of fibroids has proven to be safe, versatile, and effective in reducing or eliminating symptoms related to uterine fibroids.

Impact to Patients' Health

The procedure is well tolerated with a typically uneventful and rapid recovery requiring NSAIDs only for postoperative pain. Patients returned to everyday life 2-3 days after the procedure.

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Bridging the Gap: Early Outcomes from a Local Endometriosis Clinic in Scotland Outside a BSGE Centre

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Background

Endometriosis is a chronic gynaecological condition with a significant impact on quality of life. In the UK, advanced endometriosis cases are managed at specialist BSGE-accredited centres, but many patients first present to general gynaecology services. We established a dedicated endometriosis clinic in Scotland (outside a BSGE centre) in October 2022 to expedite diagnosis and ensure standardised high-quality management. Here we report preliminary outcomes of the first 20 patients.

Methods

Data were collected for the first 20 patients (from October 2022). All patients completed baseline patient-reported outcome measures: the Endometriosis Health Profile-5 (EHP-5) questionnaire and a pain score. All underwent pelvic ultrasound (USS), with MRI added for suspected deep disease. Patients with disease suitable for local management underwent laparoscopic surgery, while those with extensive disease were referred to a tertiary BSGE centre as per guidance. Outcomes included time from referral to diagnosis and treatment, imaging findings with staging, management pathways, and changes in PROMs at follow-up.

Results

Median time from referral to diagnostic confirmation was 12 weeks, and to initial treatment was 24 weeks. Ultrasound was suggestive of endometriosis in 15/20 patients, detecting ovarian endometriomas in 8 and deep infiltrating disease in 5. MRI, performed in 7 patients with suspected deep endometriosis, confirmed advanced disease in 5. In total, endometriosis was confirmed in 15 patients: 6 had Stage I–II (mild) and 9 had Stage III–IV (severe) disease.

Ten patients (50%) underwent laparoscopic surgery locally; intraoperative findings correlated with imaging in 80%. Seven patients (35%) were referred to the tertiary centre for advanced disease management. The remaining 3 received conservative management (analgesics and hormonal therapy). At 6-month follow-up, the median pain score dropped from 8/10 to 4/10 and the mean EHP-5 score improved from 60 to 40, indicating a marked improvement in quality of life. No major complications occurred in the local surgical group.

Conclusions

Establishment of a dedicated endometriosis clinic outside a BSGE-accredited centre is feasible and has shown early benefits. The clinic achieved timely diagnosis and initiated prompt management, with most patients treated within six months of referral. Adherence to imaging protocols and referral criteria ensured appropriate triage of complex cases to specialist centres. Early outcomes show improved pain and quality of life, suggesting this local service can effectively address patient needs

while reducing delays. Ongoing evaluation in a larger cohort will guide further service development and assess long-term patient outcomes.

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Laparoscopic Hysterectomy for Large Uteri (≥ 1 kg): Surgical Morbidity and Predictors of Complications

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Background

Objective: To evaluate the safety and surgical outcomes of laparoscopic hysterectomy for uteri ≥ 1 kg and to identify predictors of major postoperative complications, with particular emphasis on comparing laparoscopic and open approaches.

Methods

This retrospective cohort study included 464 patients who underwent hysterectomy for uteri weighing ≥ 1 kg at the Department of Obstetrics and Gynaecology, Filippo Del Ponte Hospital (Varese), between July 2000 and February 2025. Data on surgical approach (laparoscopy vs. laparotomy), operative time, estimated blood loss, hospital stay, and complication rates were analysed. Major complications were defined as Clavien-Dindo grade II or higher. Univariate and multivariate analyses were performed to identify independent predictors of major complications.

Results

Compared to laparotomy, laparoscopic hysterectomy was associated with significantly lower blood loss (100–500 mL vs. 150–600 mL; $P=0.013$) and shorter hospital stays (1–2 days vs. 2–5 days; $P=0.037$), despite longer operative times (94.5–180 minutes vs. 75–125 minutes; $P=0.004$). The overall rate of complications did not significantly differ between the two approaches. Univariate analysis identified longer operative time (108–207 min vs. 87–170 min; $P=0.0035$), greater blood loss (200–800 mL vs. 100–400 mL; $P=0.0003$), and extended hospital stay (2–5 days vs. 1–2 days; $P=0.013$) as factors associated with major complications. However, multivariate analysis revealed that only blood loss (OR=1.001, 95% CI 1.000–1.002; $P=0.01$) and hospital stay (OR=1.14, 95% CI 1.041–1.30; $P=0.02$) were independent predictors. Operative time did not retain statistical significance (OR=1.00, 95% CI 0.997–1.007; $P=0.37$).

Conclusions

Laparoscopic hysterectomy for uteri ≥ 1 kg is a safe and effective approach, offering significant advantages over laparotomy in terms of reduced blood loss and shorter hospitalisation, without an increase in complication rates. When performed in high-volume centres with adequate surgical expertise, minimally invasive surgery can be successfully applied even in complex cases involving large uteri.

Reproductive outcomes following laparoscopic repair of the caesarean section niche in women with secondary infertility and intrauterine fluid

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Background

Caesarean scar defects (niches) are asymptomatic in the majority of women, but they can cause abnormal uterine bleeding and secondary infertility. The causes of secondary infertility are not very clear, but it is quite likely that the accumulation of fluid or blood in the uterine cavity, along with abnormal vascularisation and inflammation, are significant contributors. Fluid collection in the uterine cavity particularly causes a challenge in those patients who are planning to undergo in vitro fertilisation and embryo transfer treatment, as the implantation rates are known to be substantially lower in the presence of fluid in the cavity.

Objective: To evaluate the effectiveness of laparoscopic caesarean scar niche repair in women with intrauterine fluid accumulation and secondary infertility, the majority of whom were scheduled for IVF or frozen embryo transfer.

Methods

This was a retrospective analysis, and all procedures were performed by the same surgeon. At laparoscopy, the uterovesical peritoneum was opened, and the bladder was reflected down. Concurrent hysteroscopic guidance was used to identify the location of the defect. The niche was then opened, and the defective niche walls were excised. The uterine wall was reconstructed in two layers. Postoperatively, patients were advised to avoid conception for three months and to plan for elective caesarean delivery in future pregnancies.

Results

A total of 39 patients were evaluated over an 11-year period (2014-2025). All patients were referred for evaluation due to primary symptoms of secondary infertility and fluid in the uterine cavity. The median duration of subfertility was 24 months (12–96 months), and the mean age was 36.9 (28-51) years. 28 patients (71.8%) had had one previous caesarean section, 6 (15.4%) had two, 2 (5.1%) had three, 1 (2.6%) had four, while data were unavailable for 2 patients (5.1%).

Three patients are waiting to start trying for a pregnancy or IVF treatment, as their operations took place in the last 6 months. Six patients decided against trying for a pregnancy due to several reasons, including concern about uterine rupture or lack of funding for IVF treatment. Six patients were lost to follow-up. 14/24 (58.3%) patients who continued to try for pregnancy and with known outcomes had at least one live birth. Five of these were spontaneous, and nine were the result of IVF pregnancies. Two further patients are pregnant in the third trimester and are due to deliver by elective caesarean

section. One patient had persistent fluid in the uterine cavity. Five patients had failed IVF, and one patient had a miscarriage following IVF.

Conclusions

Our data show that a significant proportion of women with a caesarean section niche and fluid in the uterine cavity conceive following laparoscopic repair.

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Single port Laparoscopy; management of severe rectovaginal endometriosis in the context of total laparoscopic hysterectomy and bilateral salpingoophorectomy to treat endometrial cancer

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Background

The single-port surgery concept is an interesting surgical concept that will require further training and practice. Case selection is important to achieve efficient surgery. This is a case of 60-year-old lady, Para 2, with very low BMI diagnosed with low-grade endometrial cancer. Preoperative assessment and preparation included MRI and a 1111 multidisciplinary meeting. The imaging did confirm stage 1A disease, but no other remarkable findings. She consented for a total laparoscopic hysterectomy and bilateral salpingoophorectomy by single port technique. This case had burnout, endometriosis and scarring of the rectosigmoid area, which was an incidental finding in this case.

Methods

The single port laparoscopy started by preparing the umbilical access through a vertical incision then direct access to the abdominal cavity. Then Alexis retractor was inserted and Gelpoint advanced platform was applied. The Voyant energy device was used. The intraoperative finding was bulky fibroid uterus with limited mobility and an obliterated Pouch of Douglas and adherent ovaries. Single-port access surgery is not as widely and frequently practised as standard laparoscopy due to the challenging triangulation.

Results

The whole procedure was continued as a single port with opening of the side walls, adhesiolysis, bilateral ureterolysis and dissection of the rectovaginal space. The intra-abdominal pressure was kept at 8mmHg, and there was no need to convert to multiport laparoscopy. The whole dissection was achieved successfully using standard laparoscopic instruments. For colpotomy monopolar hook was used and the specimen was retrieved vaginally. The vault was closed laparoscopically with good haemostasis. The operative time was 120 minutes with minimal blood loss and normal immediate recovery. She was discharged home within 48 hours with minimal pain, and a later follow-up indicated normal wound healing and no granulation tissue at the vault and complete return to function.

Conclusions

This case demonstrated the feasibility of managing surgical complexity through single-port surgery without loss or interruption of the usual flow of the operation. The success was achieved with attention to surgical anatomy, an experienced operator, and optimal settings. This is not an indication to perform endometriosis surgery through a single port, but to have an appreciation of the technique, its feasibility and safety. The advantage of this technique in the elderly, frail and low BMI is that it has minimal trauma to the anterior abdominal wall, avoiding vascular injuries and hernia. The umbilical wound will be sufficient for triangulation in a small frame abdomen, and putting lateral and suprapubic ports would have been redundant. However, this approach will heavily rely on the

experience of the operator and choosing the most efficient and the least traumatic methodology for the safe conclusion. The single port concept can be extended and enhanced by integration with robotic technique, which further its utility and applications, but through only one incision.

Laparoscopic Management of primary tubal ectopic pregnancy - a case report

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Background

The main aim of reporting primary abdominal pregnancy cases is to improve understanding and management of this rare, life-threatening condition. This includes sharing diagnostic experiences, highlighting the importance of surgical management, and contributing to the development of treatment strategies that minimise maternal mortality and in turn, improve diagnostic competence. Diagnostic Friedrich and Rankin's criteria for true primary abdominal pregnancy are the pregnancy should be less than 12 weeks of gestation and the trophoblastic attachments should be related solely to the peritoneal/serosal surface.

Methods

The authors present a case report of a 24-year-old P1 female with 8 8-week pregnancy attending the Gynaecology assessment unit. She presented with right iliac fossa pain. Bhcg levels were 1607. A transvaginal scan was carried out, which revealed an empty uterus with three phased endometrium of 10.9mm thickness. There was some haemorrhagic fluid in the P.O.D 32.5mm. The right Ovary was complex and bulky 39.2mm, and adjacent to this was a suspicious tubal/ cornual mass 13.2mm x14.2mm with a hint of a yolk sac. The findings were suspicious of an ectopic/ cornual pregnancy. A decision for diagnostic laparoscopy +_ right salpingectomy +_ proceed was taken.

Results

- Intra- op findings revealed an Ectopic pregnancy noted at the right cornual end suspected to have ruptured with sac growing outside on serosal surface of the tube. This seemed suspicious of a Secondary abdominal pregnancy – the mass was 1.5-2 cm non non-fragile and fixed to the tube. Right salpingectomy done and tissue sent for histology.

Histology revealed macroscopic findings of the fallopian tube appearing to be intact and convoluted towards the distal end. No evidence of a gestation sac at either end of the specimen. Microscopic findings revealed no evidence of reaction to ectopic pregnancy within the tubal wall or lumen. However, a few chorionic villi confirming products of conception/ectopic pregnancy were found on the serosal surface of the fallopian tube.

Conclusions

Primary abdominal pregnancies account for 1% of all ectopic pregnancies. However, the mortality is 7 times higher than a tubal ectopic pregnancy. Hence, higher clinical suspicion and increased awareness will reduce the mortality of these rare cases.

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ePoster Presentations

7 tips to tackle incidental dense bowel adhesions during a total laparoscopic hysterectomy

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Background

Video demonstration of the step-by-step adhesiolysis of dense bowel adhesions during a total laparoscopic hysterectomy

Methods

Use of Enseal X1 as an energy source and blunt dissection with scissors and suction

Results

Tip 1 search for avascular plane between mesenteric border and uterus

Tip 2 stay close to the uterus

Tip 3 avoid energy source in close proximity to the bowel

Tip 4 identify safe windows

Tip 5 blunt divergent dissection with suction improves adhesiolysis

Tip 6 Recognise clear anatomical landmarks or organs

Tip 7 Indirect approach of freeing safe tissue

Conclusions

This is an educational video for budding laparoscopic surgeons to deal with dense bowel adhesions and frozen pelvis

<https://player.vimeo.com/video/1090298324?autoplay=1>

Freeing the Ureter: A Delicate Dance with Endometriosis

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Background

Peritoneal endometriosis is a prevalent cause of chronic pelvic pain and infertility. When lesions extend to the pelvic sidewall or involve fibrotic peritoneum near the ureter, surgical excision must be both precise and cautious. Laparoscopic ureterolysis enables safe dissection and clearance of disease while preserving ureteral function. This video demonstrates a stepwise technique for laparoscopic ureterolysis and peritoneal excision using ultrasonic energy for controlled dissection and haemostasis.

Methods

This surgical video features a laparoscopic procedure performed under general anaesthesia in a patient with chronic unilateral pelvic pain and suspected ureteral entrapment due to peritoneal endometriosis. Imaging revealed fibrotic distortion of the left pelvic sidewall without hydronephrosis. Laparoscopic access was established with an umbilical primary port and three accessory trocars. The retroperitoneum was entered via a medial peritoneal incision. Ureterolysis was performed from the pelvic brim to the ureteric tunnel using an ultrasonic energy device, allowing fine dissection with minimal thermal spread. The ureter was gently mobilised, preserving its adventitia and vascular supply. Peritoneal endometriotic lesions were excised from the pelvic sidewall, uterosacral ligament, and ovarian fossa. Haemostasis was achieved without monopolar or bipolar electrosurgery.

Results

The ureter was successfully freed from surrounding fibrotic tissue, with intact peristalsis and preserved anatomy. All visible peritoneal endometriotic implants were excised. The use of ultrasonic energy provided excellent surgical field clarity and effective haemostasis. Total operative time was 78 minutes. No intraoperative complications occurred. At the 6-week follow-up, the patient reported significant pain relief and improved quality of life. Follow-up imaging showed no ureteral injury or obstruction.

Conclusions

Laparoscopic ureterolysis with ultrasonic energy is a safe and effective technique in the management of pelvic sidewall endometriosis. It facilitates precise dissection with minimal thermal damage, allowing both disease eradication and preservation of critical structures (nerves, ureter, blood vessels). This step-by-step video provides a practical guide for gynaecologic surgeons performing advanced endometriosis surgery and underscores the importance of meticulous technique in ureteral dissection.

<https://player.vimeo.com/video/1090303942?autoplay=1>

Management difficulties of a massive bilateral dermoid cyst in a young nulliparous woman, what is the best surgical approach to preserve fertility?

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Background

This is a case of 29 29-year-old who presented with a pelvic mass almost up to the umbilicus. She is nulligravida with no remarkable past history and has a normal BMI. Investigation indicated 35 cm Left dermoid cyst with 18 cm Right ovary full of multiple dermoid cysts. She had normal tumour markers and vetted cancer network meeting as ovarian cysts towards the benign end of the spectrum, hence she was booked for elective surgery on soon basis, but she presented acutely with sepsis, pain and raised inflammatory markers. She was taken for emergency surgery and consented for laparoscopy to start as a single port with the potential to proceed to laparotomy. The intention was to preserve as much ovarian tissue as possible.

Methods

The procedure started as single port surgery and this was done through 3cm vertical incision at the umbilicus and applying and positioning the Gelpoint advanced platform. It was found that there is some pus in the abdominal cavity, a huge with partially torsion left ovarian cyst, and right ovary was full of dermoid cysts and impacted in the POD. It was possible to perform left ovarian cystectomy and preserve some ovarian tissue, and the ovary was reconstructed using Stratafix. The cyst was decompressed in a controlled way to reduce its size and retrieved in an Alexis retraction system through the umbilical wound without spillage. The right ovary proved more problematic to manage, and the procedure was converted to standard laparoscopy by putting three 5mm ports. it was possible to remove 5 dermoid cysts from the right ovary, but it was not possible to do that without rupturing some of them. It was possible to preserve plenty of normal ovarian tissue which was reconstructed using Stratafix. All the specimens were extracted by contained retrieval through the umbilical wound. The specimen contained bony pieces which were difficult to retrieve; however, it was easier after removing the teeth from the bone and which avoided wound extension. In conclusion, it was found that the umbilical single port allowed the passage of big swabs to mob and clean the spillage faster than suction and irrigation. On the final survey, it was found that the source of sepsis was an inflamed appendix, which was removed laparoscopically. It was not sure whether it was a primary appendicitis or secondary to the left ovarian torsion process. The procedure took 7h, and the patient made a good immediate recovery.

Results

It was possible to preserve fertility and avoid laparotomy. The postoperative course was complicated by chest pain and fever, but the patient improved gradually

Conclusions

This demonstrated the dilemma in management, like the best approach to surgery and to operate on both ovaries and the management of multiple dermoid cysts. It also demonstrated the value of a single port in retrieval.

Opening the Gate: Hysteroscopic Management of a Stenosed Cervix"

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Background

Cervical stenosis can pose a significant challenge in office hysteroscopy and operative procedures, particularly in postmenopausal or post-surgical patients. Traditional methods of cervical dilation carry risks of trauma and uterine perforation. The MyoSure system, typically used for intrauterine tissue removal, can also aid in navigating and treating a stenosed cervical canal under direct visualisation. This video demonstrates the use of the MyoSure hysteroscopic system to safely negotiate a stenosed cervix and perform intrauterine intervention.

Methods

The video presents a case of a 53-year-old postmenopausal patient with abnormal uterine bleeding and suspected intrauterine pathology. Office hysteroscopy was attempted but encountered a complete cervical stenosis. MyoSure® hysteroscopic system was then introduced. With careful pressure and continuous irrigation, the rotating tip of the MyoSure® device was used to gently nibble and precisely widen the stenotic segment. Once the cavity was accessed, visualisation improved, and intrauterine pathology was removed under direct vision. No mechanical dilators or sepculum were used.

Results

The MyoSure device allowed successful negotiation of the stenosed cervix without trauma or cervical laceration. The internal os was gradually opened with careful mechanical morcellation of the stenosed cervical canal, permitting entry into the endometrial cavity. Intrauterine pathology was removed safely with excellent visualisation and minimal bleeding. Operative time was 14 minutes. The patient experienced no postoperative pain or complications. Follow-up confirmed resolution of symptoms and a normalised endometrial cavity on ultrasound.

Conclusions

The MyoSure® hysteroscopic system provides a valuable tool not only for intrauterine tissue removal but also for the atraumatic negotiation of a stenosed cervix. Its ability to provide real-time visualisation and controlled advancement reduces the need for blind dilation and lowers the risk of cervical or uterine injury. This video demonstrates an alternative, minimally invasive approach for managing cervical stenosis in operative hysteroscopy and may be especially beneficial in postmenopausal or high-risk patients.

<https://player.vimeo.com/video/1090311121?autoplay=1>

Development and Preliminary Evaluation of an AI-Supported Patient Education Tool for Laparoscopic Sacrocolpopexy

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Background

Laparoscopic sacrocolpopexy (LSCP) is widely recognised as the gold standard for the surgical treatment of apical pelvic organ prolapse. However, due to the procedure's complexity, effective patient education remains challenging. Standard written materials often lack individualisation and fail to adequately explain anatomical and procedural details. We aimed to develop and preliminarily evaluate an artificial intelligence (AI)-based educational tool to support structured, patient-specific counselling prior to LSCP.

Methods

We designed an AI-driven patient education system utilising a large language model (ChatGPT-4 and DeepSeek) guided by structured prompts to generate readable, medically accurate content. The tool produces tailored information regarding indications, surgical rationale, intraoperative steps, potential complications, and postoperative expectations. A prototype version was internally evaluated for linguistic clarity (Flesch-Kincaid readability index), accuracy, and perceived usefulness by clinicians and lay reviewers.

Results

The AI-generated content consistently achieved a readability level corresponding to grades 6–8 and was rated as clear, comprehensive, and medically reliable. Preliminary user feedback indicated that the tool may enhance patient understanding and informed consent. The content was positively received across a range of users, including clinicians without subspecialist training and non-medical participants. Further refinements are underway, including prompt optimisation and content expansion.

Conclusions

Next phases include usability testing in simulated patient scenarios and a controlled comparison of educational effectiveness across three groups: (1) patients receiving AI-based counselling with ChatGPT, (2) patients counselled using a DeepSeek-based model, and (3) patients receiving traditional physician-led education. In parallel, a multicentre validation study will assess generalizability across languages, cultural contexts, and institutional settings. If proven effective, this tool may serve as a scalable adjunct to enhance standard counselling practices in pelvic reconstructive surgery.

<https://esge.covr.be/cmdocumentmanagement/conferencemanager/documents/api/getdocument/15036/cmabstsms/0000228850/80a4f52c2dca66bb0fcd9a7df7daa6fee98f5786f6d25813d707d5ffedbbbe2>

A video case series comparing two different surgical techniques of robotic-assisted ureteric re-implantation following excision of Deep Infiltrating Endometriosis

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Background

Robotic-assisted surgery has become an increasingly valuable tool in complex pelvic procedures. We present a video case series comparing two different robotic techniques for ureteric re-implantation following excision of endometriosis—one performed in the context of hysterectomy, the other in a fertility-sparing approach.

Methods

In the first case, a robotic-assisted hysterectomy was performed with excision of endometriosis and left ureteric re-implantation. The damaged ureteric segment was excised, and the ureter was reimplanted over the uterus into the bladder. In the second case, a fertility-sparing excision of deep endometriosis was undertaken, with right ureteric re-implantation performed by creating a window through the broad ligament and tunnelling the ureter through it prior to implantation into the bladder. Both procedures were performed using a multiport robotic platform with wristed instruments, and the surgeries were video-documented.

Results

There was no significant difference in operative time between the two cases. Both patients had normal postoperative urea and electrolyte levels and maintained good urine output. Ureteric stents were placed in both cases, with planned cystoscopic-guided removal coordinated with urology. No intraoperative or immediate postoperative complications were noted.

Conclusions

Both ureteric re-implantation techniques are surgically challenging. However, the robotic approach enhances surgical precision and ergonomics. In particular with opening the bladder to reimplant the ureter and performing multiple surgical knots, the robot has significantly improved efficiency and reduced operating times. The use of wristed instruments facilitates dissection and suturing in confined pelvic spaces, particularly when accessing the broad ligament, ensuring small windows are made and a conservative and precise approach is taken during dissection. These technical advantages may support broader use of robotic assistance in complex ureteric reconstructions associated with endometriosis surgery.

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The Unexpected Diagnosis of Intra-abdominal hemorrhage: ectopic pregnancy from ligated tuba

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Background

Here, we report a clinically rare case of a patient with ruptured tubal ectopic pregnancy occurring eight years after bilateral tubal ligation (BTL), highlighting the critical role of clinical vigilance and the efficacy of laparoscopic management in an emergency setting.

Methods

A 34-year-old multiparous woman who had undergone BTL eight years ago presented with acute lower abdominal pain for the last few hours. She was fully conscious, in pain, anxious, and afebrile. The patient was borderline stable (BP: 90/60 mmHg, HR: 115 bpm) with additional generalised abdominal tenderness, guarding and rebound tenderness, and cervical motion tenderness. Serum β -hCG levels were elevated at 19,815 mIU/mL. Ultrasound scan showed a tender echo-complex right adnexal mass, free fluid of a haemorrhagic nature in the cul-de-sac and an empty uterine cavity, consistent with a ruptured right ectopic pregnancy. An urgent exploratory laparoscopy was performed and showed evidence of a ruptured right distal tube containing products of conception, haemoperitoneum and a ligated left tube (Figure 1). A right total salpingectomy was performed, and the resected right tube containing the mass was sent for histological examination.

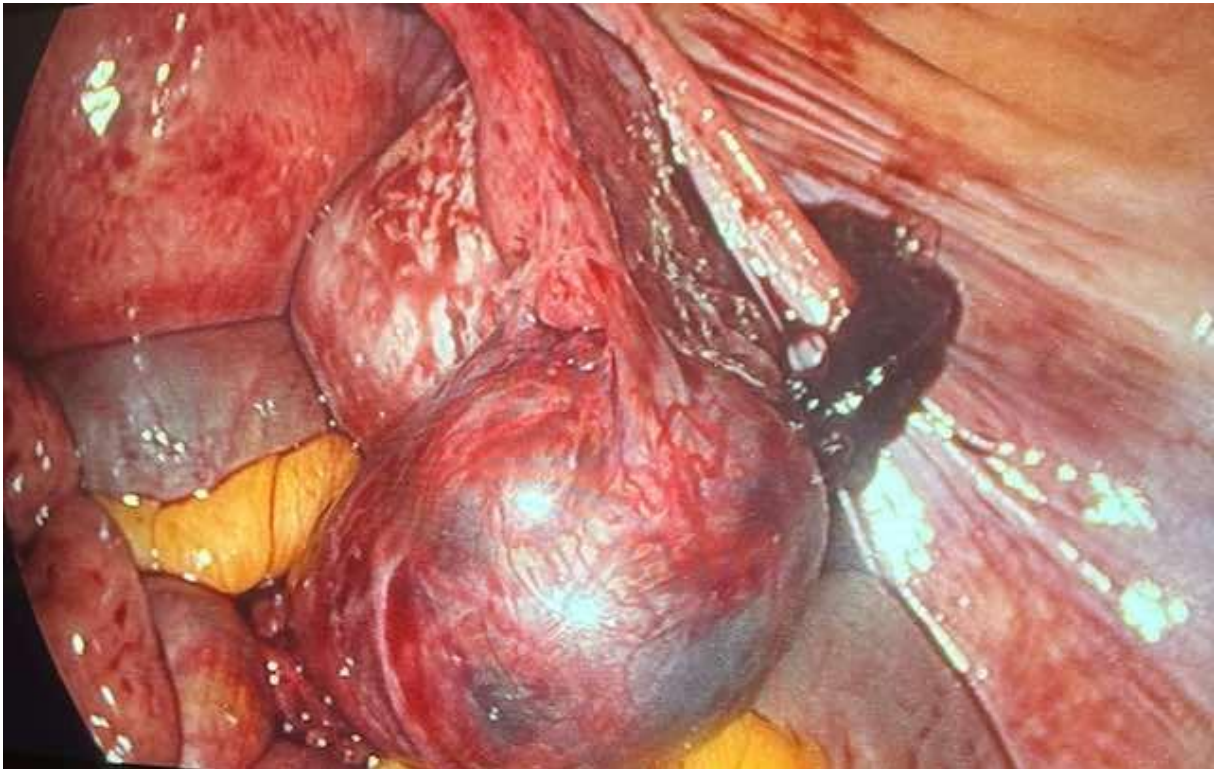


Figure 1. Image of a ruptured ectopic focus in the right fallopian tube.

Results

The patient's postoperative recovery was uncomplicated. Serial β -hCG levels demonstrated an appropriate decline: 9,422 mIU/mL on postoperative day one and 284 mIU/mL at one-week follow-up. Histopathological analysis revealed chorionic villi and haemorrhagic vascular decidual tissue in the fallopian tube, features suggestive of a tubal ectopic pregnancy.

Conclusions

Although ectopic pregnancy following BTL is uncommon, it remains a potentially life-threatening condition that warrants consideration in reproductive-aged women presenting with abdominal pain, even years after sterilisation. This case underscores the feasibility and effectiveness of laparoscopic intervention in acute settings, facilitating prompt recovery and optimal patient outcomes.

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Telemedicine-Supported, Stratified Conservative Management of Stress Urinary Incontinence in Rural Kazakhstan: A Population-Adaptive Pilot Study

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Background

Stress urinary incontinence (SUI) remains a common and under-treated condition among women in rural Kazakhstan, where access to urogynaecologic care is limited. This study aimed to evaluate the feasibility and outcomes of a stratified conservative treatment program enhanced by telemedicine and culturally adapted education.

Methods

Women aged 30–55 years with grade I–II stress urinary incontinence were recruited from four rural outpatient clinics. Based on the SUI-Rural Score (age, parity, BMI, symptom severity, pelvic floor strength), participants were allocated to two groups:

- Group A: PFMT + biofeedback (n=50)
- Group B: PFMT + biofeedback + electrical stimulation (n=30).

Women with intrauterine devices were excluded from Group B. All participants received weekly video consultations and Kazakh-language educational videos. Outcomes included Oxford score, ICIQ-SF, bladder diary, satisfaction, and adherence.

Results

All 80 participants completed the 12-week program. Oxford Scale scores improved significantly in both groups: Group A (n=50): from 2.4 to 3.7; Group B (n=30): from 2.3 to 4.2; $p<0.01$. The ICIQ-SF score decreased by 44% in Group A (from 15.1 to 8.4) and by 67% in Group B (from 14.8 to 4.8); $p<0.001$. Weekly leakage episodes were reduced from 5.2 to 2.5 in Group A (mean reduction 2.7 episodes) and from 5.0 to 1.1 in Group B (mean reduction 3.9 episodes); $p<0.001$. Patient satisfaction scores $\geq 8/10$ were reported by 70% of Group A and 90% of Group B. Mean teleconsultation attendance was 6.7 (SD \pm 0.9) of 12 sessions in Group A, and 7.1 (SD \pm 0.7) in Group B. Subgroup analysis by SUI-Rural Score revealed greater relative improvement in participants with higher scores allocated to stimulation therapy. Post-intervention questionnaires indicated increased pelvic health awareness in 83% of respondents; 68% reported reduced embarrassment discussing SUI symptoms. No adverse events occurred.

Outcome	Group A (n=50)	Group B (n=30)	p-value
Mean age (years)	43.3 \pm 6.2	42.8 \pm 6.4	—
Mean BMI (kg/m ²)	28.5 \pm 3.8	29.0 \pm 4.1	—

Outcome	Group A (n=50)	Group B (n=30)	p-value
Oxford Score (baseline → 12 wks)	2.4 → 3.7 (95% CI [2.2–2.6] → [3.5–3.9])	2.3 → 4.2 (95% CI [2.1–2.5] → [4.0–4.5])	<0.01
ICIQ-SF	15.1 → 8.4 (95% CI [14.4–15.8] → [7.7–9.1])	14.8 → 4.8 (95% CI [14.0–15.6] → [4.2–5.4])	<0.001
Weekly leakage episodes	5.2 → 2.5 (95% CI [4.8–5.6] → [2.2–2.8])	5.0 → 1.1 (95% CI [4.6–5.4] → [0.8–1.4])	<0.001
Satisfaction ≥8/10	70%	90%	—
Teleconsultation adherence	6.7 / 8 (SD ± 0.9)	7.1 / 8 (SD ± 0.7)	—
↑ Knowledge/self-awareness	80%	86%	—

Conclusions

A stratified, telemedicine-enhanced conservative treatment model is both feasible and effective for women aged 30–55 in remote Kazakhstani regions. The integration of culturally adapted education and remote supervision improves adherence, outcomes, and patient engagement. These findings support the development of a sustainable, scalable care model that can be implemented within the existing primary healthcare system across underserved communities.

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Innovative Approach To Surgical Treatment In Central Placenta Previa

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Background

Central placenta previa remains one of the most dangerous forms of abnormal placental attachment, associated with a high risk of severe obstetric haemorrhage, maternal and perinatal morbidity, and mortality. Despite advancements in surgical and anaesthetic techniques, the management of this pathology still requires the refinement of clinical strategies for pregnancy and delivery.

Methods

This study included 115 pregnant women diagnosed with central placenta previa. The participants were divided into two groups. The first group comprised 30 patients whose data were evaluated retrospectively; all underwent hysterectomy due to life-threatening indications. The second group included 85 patients managed using a novel uterine-preserving surgical technique developed by our team (Eurasian Patent No. (11) 046838 (13) B1). Diagnostics were based on clinical and anamnestic evaluation, ultrasound and Doppler studies, and, when indicated, magnetic resonance imaging (MRI). Laboratory assessment included haemostasis parameters (coagulogram, hemostasiogram) and, when necessary, extended biochemical testing.

The innovative approach incorporates the following key surgical elements:

1. Incision above the placental zone, which avoids injury to the feeding vessels and significantly reduces blood loss.
2. Temporary tamponade of the uterine cavity after foetal extraction, creating mechanical compression and preventing massive haemorrhage.
3. Rotation of the uterus into the lower abdominal cavity, facilitating optimal access to the organ's vascular supply.
4. Ligation of the iliac and sacral arteries using catgut sutures, temporarily halting uterine blood flow and aiding in haemostasis.
5. Returning the uterus to its anatomical position after achieving haemostatic control.
6. Removal of the tampons and staged, controlled placental separation, allowing for safe completion of the surgery with preservation of uterine integrity.

Results

All patients (100%) underwent caesarean section. The mean maternal age was 36.5 ± 15.5 years. According to gestational age, central placenta previa was most commonly observed at 33-37 weeks ($n = 51$; 44.3%), 38-40 weeks ($n = 38$; 33.1%), 28-32 weeks ($n = 21$; 18.3%), and 20-27 weeks ($n = 5$; 4.3%). Clinical analysis revealed a high incidence of preterm deliveries (67%) and haemorrhage of varying severity (52.2%).

Special attention should be paid to the frequency of prior uterine surgeries: 53 women (46.1%) had one uterine scar, 35(30.4%) had two, and 9 cases (7.8%) had three. The mean intraoperative blood loss in

the retrospective group was 2250 ± 1750 ml, compared to 700 ± 200 ml in the prospective group - a statistically significant difference ($p < 0.05$), clearly indicating the effectiveness of the proposed technique.

Conclusions

Preserving the reproductive potential of women undergoing cesarean delivery for central placenta previa remains a pressing concern in modern obstetric surgery. The proposed method offers an effective strategy to prevent massive blood loss, reduces the need for hysterectomy, and contributes to favourable postoperative recovery.

Assessment of sexual function in women after colpoperineoplasty and transobturator tape surgeries

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Background

According to WHO, one of the most important criteria for quality of life is the state of physical, emotional, spiritual, and social well-being. Sexual dysfunction is a group of heterogeneous disorders manifested by changes in sexual response and capacity for sexual pleasure. Female sexual dysfunction is considered a public health problem affecting 40% of the world's women.

The main goal of our study was to evaluate surgical outcomes and compare the effects of anterior colporrhaphy and transobturator tape surgery on female sexual function. For diagnostics, we used anamnestic data, gynaecological examination, laboratory and instrumental method

Methods

For assessment of sexual function, we used Female Sexual Function Index The Female Sexual Function Index (FSFI) is a psychometrically reliable and popular self-report measure consisting of a questionnaire, the use of which allows for the differential assessment of clinical manifestations of sexual dysfunction. The questionnaire includes 19 items. Each question is scored from 0 to 6 points. Minimum score is 2, maximum is 36 points.

For our study, we investigate 18 patients aged 34-43 years old after anterior colporrhaphy 1-st group and the 2-nd one - 21 women (38-45) with SUI (stress urinary incontinence) after transobturatortape surgery .

Results

Before the operation, the minimum index value among the interviewed patients of 1-st group was 5, and the maximum was 15, in the second group minimum score was 7, and the maximum was 12, because all of the has sexual dissatisfactions. Complaints included the decrease of sensitivity, orgasmicity, satisfaction and dyspareunia in the first group and the second group of women had same issues, but more often they had psychological problems, depends on urine discharge during sex and SUI. The survey was repeated 3 months after surgery, and the score range was 13–26. Complaints of pain, orgasmicity and satisfaction remained. But the sensitivity has noticeably increased.

Conclusions

After 6 months, significant progress was noted and the score range increased up to 29-36 in the first group of women and to 26-34 at the second group. The second investigation group has definitely improved their sexual life after 6 months. Dyspareunia disappeared in 100% of investigated patients, which supports using transobturator tape surgeries on women with SUI and vaginal prolapse. The percentage of satisfaction and orgasmicity also increased noticeably.

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Ovarian Endometriosis and its management with Diode Laser

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Background

Endometriosis by definition, is the presence of endometrial tissue (both gland and stroma) outside the uterus. Tissue is morphologically and functionally similar to endometrial tissue – responds to hormones in a cyclic manner. There are several theories associated with the development of endometriosis, such as Samson's theory of menstrual regurgitation and implantation (Metastatic theory), coelomic metaplasia theory, lymphatic and vascular metastasis theory, genetical factors, and inflammation, but still there is no concrete aetiology found. Today, the best approach for endometriosis is endovisual surgery. The effect of the diode laser in endometriosis management is highly positive.

- Management of ovarian endometriomas with Diode laser.
- The effect of diode laser on the ovarian function and ovarian reserve.
- The general outcome of ovarian endometriosis patients after laparoscopy and diode laser surgery.

Methods

Our case presents a patient with Deep infiltrative endometriosis and ovarian endometrioma, complaining of chronic pelvic pain and infertility. The patient underwent laparoscopic surgery, diode laser ablation of endometrioma and endometriosis lesions.

Results

Endovisual surgery, diode laser ablation provided complete destruction/vaporisation of endometriosis lesions. Post-op outcome was positive, pain has passed completely. Anti-Mullerian Hormone undergoes no decline. Five months post-op patient has positive pregnancy results

Conclusions

The benefits of diode laser usage in endometriosis patients, specifically ovarian endometriomas, are clear. Evaluation of ovarian reserve, AMH, shows that the diode laser presents a good option for treating endometriosis

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Technique of transabdominal laparoscopic cerclage in cervical insufficiency

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Background

Cervical insufficiency occurs in 1% of pregnancies. The most common factor in cervical insufficiency is anatomical-structural changes. The gold standard for cervical length assessment is transvaginal ultrasound. Among the treatment methods, cervical cerclage takes a special place. Unsuccessful vaginal cerclage, cervical length < 2cm, and rough cervical scar are indications for transabdominal laparoscopic cerclage. Transabdominal laparoscopic cerclage differs from other methods in that it can be performed before pregnancy, less blood loss, minimal invasiveness, and the cerclage suture can be kept in place for subsequent pregnancies.

The purpose of the study. Identify the most effective and least invasive surgical technique for cases where transvaginal laparoscopic cerclage is not a viable option.

Methods

Between 2020 and 2023, we performed transabdominal laparoscopic cerclage in 36 patients. These patients were divided into 2 groups: The first group consisted of 24 non-pregnant patients, while the second group consisted of 12 pregnant patients. All 36 patients had a history of multiple miscarriages and early births with vaginal cerclage at 21±6 weeks. The surgery was performed under general endotracheal anaesthesia. A 10 mm umbilical, 10 and 5 mm auxiliary ports were entered into the abdominal cavity under dorsal lithotomy. The vesico-uterine peritoneum was opened, and the lower segment of the uterus was dissected from the bladder. Using Ethicon (Mersilen) thread, a suture was placed between the uterine isthmus and the internal cervical os, passing 1 cm above the uterosacral ligaments. The suture was placed lateral to the uterus and medial to the uterine arteries. In one pregnant patient, the knot was tied in the front, and in the others, the knot was tied behind. Among the patients in the second group, the operation was performed on one pregnant woman in the 8th week, and on the other 11 pregnant women in the 12th week. After the surgery, an ultrasound examination showed that the amniotic sac was full, and positive cardiac activity was observed in the patients who entered the second group. In both groups, 1 gr of cefazolin was administered at 8 and 16 hours before and after surgery

Results

21 patients in group I got pregnant within 5-10 months. 19 pregnant women underwent caesarean section at 37-38 weeks. One pregnancy failed to develop at 12 weeks. One patient underwent a caesarean section at 34 weeks due to preeclampsia. In group II, 11 pregnant women underwent caesarean section at 37-38 weeks (weight 2900±400). It is noteworthy that no intra- or postoperative complications were observed in either of the groups, and the hospital stay was limited to one day.

Conclusions

Transabdominal laparoscopic cerclage is a highly effective method that can be employed when vaginal cerclage is either not a viable or an ineffective option.

Evaluation of the effectiveness of metroplasty in combination with PRP therapy for uterine scar failure after cesarean section.

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Aim

The aim of the study was to determine the effectiveness of combined metroplasty in patients with uterine wall scar failure after CS.

Background

In metroplasty of an insolvent uterine scar, the use of (platelet-rich autoplasm) PLA is recommended to improve the regeneration processes and the formation of mature connective tissue, which improves the hemocirculatory capabilities of the uterine suture repair processes (97.8%) and ensures the implementation of reproductive plans in 71.1% of women.

Materials / Patients

96 patients with a confirmed diagnosis of uterine scar failure.

Methods / Results

Laparoscopic metroplasty was performed in 96 patients with a confirmed diagnosis of uterine scar failure, of which 45 women were given platelet-rich autoplasm (PLA) during metroplasty, and the remaining 51 women were not given PLA during metroplasty. Ultrasound and Doppler imaging of the pelvic organs were performed dynamically after surgery, and the parameters (the smallest thickness of the myometrium in the lower uterine segment, the presence of inclusions and/or cystic formations in the same area) were assessed.

Discussion

When using PLA, echographic signs of hematomas were not detected in any case, which is significantly less compared to the group where only metroplasty was performed ($p < 0.05$). In the group of women where PLA was not used, the frequency of hematomas was 5.9%. This allows us to conclude that PLA has a better haemostatic effect. Hemocirculatory changes under the influence of platelet-rich autoplasm are characterised by a decrease in peripheral vascular resistance indices in the uterine vessels in the suture area and improved blood flow in the early stages after metroplasty, good vascularisation of the myometrium in the scar area in 97.8% of patients 3 months after surgery. These indicators in the group of women who did not use PLA were noted less often and were observed only in 33 (64.7%) women. Surgical correction (metroplasty) using PRP therapy made it possible to ensure the implementation of reproductive plans in 71.1% of women.

Conclusion

Confirmation of the diagnosis of an insufficient suture (scar) on the uterus is an indication for metroplasty. In metroplasty of an insufficient scar on the uterus, the use of PLA is recommended to improve the regeneration processes and the formation of mature connective tissue.

Impact on Patients' Health

there was not found No impact factors to the patients' health during the treatment.

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Opening of Yabuki's space in benign gynaecologic surgery – our experience

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Background

Surgical resection of any pathology requires adequate exposure, meticulous dissection for isolation, and proper haemostasis. Complete, effective, and safe performance directly depends on a thorough understanding of detailed anatomical structures and the specific features of the lesion, as determined by preoperative evaluation and prior experience. In advanced gynaecologic surgery, particular attention is given to the lateral paravaginal and parametrial connective tissues, which contain vital structures such as the distal ureter, vascular branches, and pelvic nerves. Although previously emphasised primarily in oncologic surgery, this area has become increasingly relevant in the context of benign gynaecologic conditions

Methods

We retrospectively analysed complete video recordings of **1,142** moderate and advanced benign laparoscopic procedures (excluding isolated non-endometriotic adnexal surgeries, myomectomies, and pelvic floor reconstructions) performed at our centre by the same surgical team from **2020 to the first quarter of 2025**. We aimed to identify cases involving lateral parametrial involvement where Yabuki's space was opened either due to pathological necessity or intraoperative decision.

Results

Yabuki's space was opened in **19 cases (1.7%)**, distributed as follows:

- **Total laparoscopic hysterectomy (TLH):** 3 cases (15.7%)
- **Deep endometriosis excision:** 7 cases (36.8%)
- **Post-caesarean isthmocele and scar pregnancies:** 7 cases (36.8%)
- **Vesicovaginal fistulas:** 2 cases (10.5%)

Of these, **16 patients (84.2%)** had a history of prior pelvic surgery, including hysterectomy, caesarean section, or endometriosis surgery.

Among the **308** patients in our cohort diagnosed with endometriosis, **270 (87.6%)** showed lateral parametrial involvement. In some of these cases, the area below and distal to the uterine artery was dissected; however, Yabuki's space was specifically opened only in the 19 cases mentioned above.

In certain laparoscopic hysterectomy cases, extensive lateral dissection was necessitated due to the inability to use a standard uterine manipulator with a colpotomy cup.

Conclusions

Yabuki's space represents a valuable anatomical corridor in advanced laparoscopic surgery for benign gynaecologic conditions. With proper anatomical understanding and surgical technique, accessing this space can enhance surgical safety and broaden the applicability of minimally invasive approaches. Furthermore, in complex cases such as the coexistence of deep infiltrating endometriosis (DIE) with indications for TLH, there is a need to reconsider the routine use of uterine manipulators.

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Management of postoperative urinoma and metallic clip migration to the ureter after tlh with die excision

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Background

A considerable number of publications in the scientific literature demonstrate the feasibility of advanced surgical approaches for extensive deep infiltrating endometriosis (DIE). However, this type of surgery is associated with major intraoperative and postoperative complications, especially when adjacent organs are involved in the pathological process. Surgeons should be aware of all potential complications, including the rarest cases, before undertaking such complex procedures.

Methods

This is the case of a 46-year-old nulligravida with severe pelvic pain, large bilateral endometriomas, and sonographic and clinical signs of retrocervical and lateral pelvic endometriosis. Her surgical history included:

1. Open right-sided endometriosis surgery in 2010
2. Opened "psoas bladder hitch" procedure with right ureteral reimplantation in 2013

Following comprehensive preoperative preparation and counselling, she underwent total laparoscopic hysterectomy (TLH) with bilateral adnexectomy, adhesiolysis, ureterolysis, and extensive DIE excision on 19.11.2023 at our clinic. The ENZIAN classification was P3 T3x/3x A3 Fu. Intraoperative bleeding from the left deep uterine vein branches was controlled with the placement of three metallic clips.

Results

Postoperative pain relief was achieved. However, two weeks after discharge, the patient was readmitted with persistent nausea and vomiting. Although contrast-enhanced CT showed no signs of urinary leakage, diagnostic laparoscopy performed by general surgeons revealed small bowel loops adherent to the previous surgical site, which were released.

Two days later, the symptoms recurred. A repeated contrast CT scan this time revealed a left-sided pelvic urinoma. Following urological consultation, a double-J stent was placed in the left ureter.

Three months later, during removal of the stent, migration of one of the metallic clips into the ureteral wall was diagnosed, and the patient was re-stented. On 21.11.2024, she underwent laparoscopic re-adhesiolysis, removal of the migrated clip, and suturing of the defect in the left ureter. During this procedure, an unintended opening of the vaginal stump occurred. A new double-J stent and bladder catheter were left in place.

The patient experienced vaginal urinary leakage, which resolved spontaneously over the following three months. Upon confirming normal urinary passage through imaging, the stent and catheter were removed. At the time of the latest follow-up, the patient was satisfied with the outcome and had no complaints.

Conclusions

Severe complications, even when not life-threatening, are characteristic of advanced DIE surgery. These complications can significantly impact a patient's quality of life and often require long-term follow-up and complex reoperations. Their management should be conducted within the framework of postoperative care involving a multidisciplinary specialists team

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Pregnancy after Tompkins metroplasty for Robert's uterus

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Background

Robert's uterus is one of the rarest Müllerian abnormalities. It is distinct from a septate uterus in that the uterine septum in Robert's uterus asymmetrically splits the uterus into one cavity, which communicates externally via the cervix, and another cavity, which does not communicate externally. In all cases of Robert's uterus, the endometrium is active and therefore most cases present soon after menarche with painful periods, but some can present later with infertility, often associated with endometriosis. Various repair techniques have been used, but we use Tompkin's Metroplasty to correct this anomaly.

Methods

Two patients presented as early adolescent with regular painful periods which did not respond to simple painkillers. The symptoms had negatively affected the quality of life. On abdominal examination, there was mild tenderness in the lower abdomen. Vaginal examination was declined as the patient was not sexually active.

Transabdominal ultrasound scan and MRI scan confirmed the diagnosis of an asymmetrical uterine septum dividing the uterus into a non-communicating cavity on one side and a contralateral cavity on the other side, which communicated externally via a normal-looking cervix and vagina.

TREATMENT:

Neither patient A and B were not sexually active and did not consent to a vaginal/hysteroscopic surgical approach. At laparotomy, the blind uterine horn was readily identifiable as it was distended with haematometra. The decision was made to perform Tompkins metroplasty. A sagittal uterine incision was made along the septum, bisecting the uterus into two halves, then a longitudinal incision was made along the uterine septum, draining the haematometra. No uterine tissue was excised. The two cavities were then sutured together in two layers with number 2/0 Vicryl (polyglactin) suture, forming one large cavity, no intrauterine catheter or device was used. I

Results

Patient A resumed normal menstruation and got married 3 years after the operation, and then got pregnant 6 months afterwards. She had an uneventful pregnancy until 36 weeks of gestation, when she went into preterm labour and was delivered by emergency caesarean section. She then conceived spontaneously 6 months later. She is in her second trimester of an uneventful pregnancy.

Patient B resumed normal menstruation with minimal pain. She is still not sexually active 4 years later.

Conclusions

We propose using the Tompkins metroplasty technique in the repair of Robert's uterus. Resection of the septum hysteroscopically or via a laparotomy and a hysterotomy has been reported before, but Tompkins metroplasty offers the advantage of using the uterine septal tissue in the repair rather than resecting it. The two sides of the septum are used to reconstruct the new unified cavity, which will have a bigger potential capacity and therefore may be less vulnerable to preterm labour. This is especially useful if the septum is thick.

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A multicenter study of laparoscopic versus laparotomic surgery in the treatment of stage I adult granulosa cell and Sertoli-Leydig cell tumours

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Background

The aim of the study is to compare oncologic outcomes between laparoscopic and laparotomic surgery in stage I adult granulosa cell and Sertoli-Leydig cell tumours.

Methods

A total of 337 patients with adult granulosa cell (n=288) and Sertoli-Leydig cell tumour (n=49) between February 2001 and April 2022 were included. Clinicopathological features were evaluated for association with relapse. Disease-free survival (DFS) was estimated using the Kaplan-Meier method. Based on Cox proportional hazard regression model with a backward elimination method was used to determine prognostic factors for DFS.

Results

The median follow-up time was 53.0 months (range, 6 to 230 months). In 157 patients who underwent laparotomy, 12 (7.6%) had disease recurrences (7 peritoneal seedings). Even though the tumours removed through MIS were generally smaller compared to those removed through laparotomic surgery (6.0 cm vs. 10.0 cm, $p < 0.001$), a higher proportion of the MIS cases involved the technique of tumour morcellation (44.4% vs. 5.7%, $p < 0.001$). Among 180 patients who had laparoscopic surgery, 21 (11.7%) showed disease recurrence (15 peritoneal seedings). The 5-year DFS rates were not different between the two groups (95.9%, laparotomic surgery vs. 96.3%, MIS). However, 10-year DFS rates were significantly different between the two groups (74.3%, open surgery vs. 53.9%, MIS; $p = 0.040$). In particular, the recurrence rate after 5 years was often significantly higher in the MIS group compared to the laparotomic surgery group. In multivariate analysis, the risk factors associated with disease recurrence were FIGO stage IC (OR, 3.058; 95% CI, 1.482-6.312, $p = 0.002$) and morcellation of ovarian tumour (OR, 2.848; 95% CI, 1.432-5.663, $p = 0.003$).

Conclusions

In stage I adult granulosa cell and Sertoli-Leydig cell tumours, the recurrence rate of laparoscopic surgery was higher than that of laparotomic surgery, and most recurrences was peritoneal seedings. Therefore, a careful approach may be needed in deciding whether to perform laparoscopic surgery on these patients. In addition, a surgical procedure should be performed to avoid morcellation of the tumour.

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Application of Transumbilical Laparoendoscopic Single-site Adnexectomy in Menopausal Patients with Ovarian Benign Tumour in Qinghai Area

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Background

To observe the effectiveness of laparoendoscopic single-site (LESS) adnexectomy in menopausal patients with ovarian benign tumour in the qinghai area.

Methods

From January 2019 to January 2024, 51 menopausal patients with ovarian benign tumour who underwent oophorocystectomy were collected and divided into LESS group(n=25) and the multi-port laparoscopic surgery group(n=26) in our hospital. The intraoperative indexes (bleeding volume, intraoperative cyst rupture, the conversion to laparotomy, operation time), postoperative indexes (postoperative use of analgesics, postoperative complications, postoperative hospital stay, incision healing, recurrence) were analysed.

Results

All cases were successfully completed. There were no patients converted to laparotomy. In LESS group, shorter postoperative hospital stay, less intraoperative cyst rupture lower postoperative pain scores compared to the multi-port laparoscopic surgery group($P<0.05$). There was no significant difference in bleeding volume、operation time、postoperative use of analgesics、incision healing between the two groups($P>0.05$). There were no complications after the operation, and no recurrence during the short-term follow-up.

Conclusions

The transumbilical laparoendoscopic single site adnexectomy is safe and feasible in menopausal patients with ovarian benign tumour.

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Parasitic Myoma: Mimicking Deep İnfiltrative Endometriosis Nodule

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Background

Parasitic fibroids are formed when fibroids spread into the abdominal cavity as a result of torsion or morselisation, adhere to the surrounding tissues and blood supply. Parasitic fibroids may be asymptomatic or cause symptoms such as pelvic pain, abdominal mass, dysmenorrhea, dyspareunia, and constipation. Patients who develop parasitic fibroids after previous surgery may take 2 months to 15 years to be diagnosed.

Methods

A 34-year-old woman presented with pelvic pain radiating to the legs, constipation and spotting bleeding lasting 10-15 days. Her history included laparoscopic myomectomy and caesarean section. Ultrasonography revealed an 11 mm isthmocele, a 33 mm subserous myoma, a 9 mm deep infiltrative endometriosis nodule on the left behind the uterus and a 13 mm endometrioma on the left ovary. Laparoscopic endometriosis surgery + hysteroscopic isthmoseal repair was planned

Results

Intraoperative findings during laparoscopic surgery revealed a 1 cm deep infiltrative endometriosis nodule on the left ovary. A 3 cm parasitic fibroid was observed on the right sacrouterine ligament. When the right ureter was dissected, a 1 cm parasitic myoma was observed on the right sacrouterine ligament. Both fibroids were excised. Left sacrouterine nodule excision and hysteroscopic isthmoseal surgery were performed, and the operation was terminated. The patient was discharged on postop day 1. The pathology result was reported as a myoma.

Conclusions

Parasitic myoma due to morcellation during laparoscopic myomectomy/hysterectomy is increasingly being detected. The possibility of parasitic myoma should be kept in mind in patients with previous surgery and pelvic pain

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VIDEO ePOSTERS

ESGE34-0019 - VP007

Video in ePoster

Pelviscopic Cul-de-sactomy of deep endometriosis - Safe and simple 5 steps –

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Background

In cases of deep endometriosis with cul-de-sac obliteration, there is a high risk of bowel or ureteral injury during adhesion dissection. Based on years of experience, I aim to introduce you my surgical video of a safer and simpler five-step pelviscopic cul-de-sactomy for patients with deep endometriosis with the patient's consent.

Methods

The principles of the procedure are as follows. First, adhesiolysis near the bowel serosa must be performed using a cold cut. Second, the feeding vessels of the ureter should be largely preserved. Third, if coagulation is necessary, it must be performed only after separating the vessels from the ureter. Lastly, peritonectomy should begin at the normal serosa. And the safe and simple five steps of pelviscopic cul-de-sactomy are as follows:

1. Ovary Suspension – After cystectomy, the sutured ovary is moved to the pelvic wall by pulling the thread.
2. Pararectal Space Identification – Locate the pararectal space between the rectum and adhesion tissue.
3. Ureterolysis & Peritonectomy – Perform ureterolysis and remove the peritoneum between the ureter and rectum.
4. Recto-Uterine Adhesion Separation – Carefully separate dense adhesions between the rectum and uterus using a cold cut.
5. Residual Endometriotic Tissue Removal – Excise all remaining endometriotic tissue completely.

Results

After more than 100 cases of pelviscopic cul-de-sactomy for deep endometriosis, bowel and ureteral injuries have been exceedingly rare.

Conclusions

The "**pelviscopic cul-de-sactomy of deep endometriosis – easy and simple 5 steps**" method is expected to provide a safer and more straightforward approach to adhesion dissection

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Surgical excision of perianal endometriosis: a case-based surgical video

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Background

Endometriosis is defined as the presence of endometrial glands and stroma outside the uterus. It is highly prevalent among women of reproductive age and is most commonly found in the pelvis, particularly on the peritoneum, ovaries, and deep pelvic structures. However, extraperitoneal endometriosis is uncommon. Perianal endometriosis is rare, with an incidence of only 0.2%, and is often associated with episiotomy scars. In this study, we aimed to demonstrate the surgical management of perianal endometriosis.

Methods

We present the case of a 33-year-old female who presented with a lump in the right perianal region, cyclical pain during menstruation, and dyspareunia.

She had a history of one spontaneous vaginal delivery and one previous episiotomy. She also underwent surgery for perianal endometriosis in 2020.

There were no signs or symptoms of perianal abscess.

Ultrasonography and magnetic resonance imaging (MRI) of the perianal and anal region revealed a solid lesion measuring approximately 32 × 10 mm in the right perianal area, adjacent to the external anal sphincter.

Under general anesthesia, dissection was performed through the right ischioanal fossa, and the endometriotic nodule was excised with careful preservation of the external and internal anal sphincters. The excised area was then sutured.

Results

No intraoperative or postoperative complications occurred.

Excision of the nodule through meticulous dissection proved to be both effective and safe.

Pathological examination confirmed the diagnosis of endometriosis.

The outcomes were highly satisfactory, with no major complications.

Conclusions

We demonstrate the surgical excision of perianal endometriosis. Dissection was performed in close proximity to the external anal sphincter and rectal wall, highlighting the importance of careful technique during dissection and suturing to preserve sphincter function. Early intervention can significantly improve patient quality of life, and definitive diagnosis can only be made through histopathological examination.

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Correlation Of Neutrophil-To-Lymphocyte Ratio (NLR) With The Severity Degree Of rASRM Score In Endometriosis Patients Undergoing Laparoscopy At Mohammad Hoesin Central General Hospital Palembang, Indonesia

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Background

The mechanism of endometriosis involves subclinical systemic inflammation characterized by an increase in circulating leukocytes, neutrophilia, and relative lymphocytopenia. There is a hypothesis that the severity of endometriosis, as indicated by the rASRM (Revised American Society for Reproductive Medicine) score, is also related to the degree of inflammation, as indicated by an increase in the Neutrophil-to-Lymphocyte Ratio (NLR). This study aimed to determine the correlation of NLR values with rASRM scores in endometriosis patients who underwent laparoscopy at Dr. Moh. Hoesin Central General Hospital Palembang, South Sumatera, Indonesia.

Methods

Patients aged 18-50 years with endometriosis with complete peripheral blood examination who underwent laparoscopic surgery at Dr. Moh Hoesin Central General Hospital Palembang, South Sumatera, Indonesia. Patients with infections, those currently using contraceptives, or on hormonal medications were excluded from this study. This research uses an observational analysis study with a cross-sectional design to determine the correlation between NLR and the rASRM score in endometriosis patients. Spearman's rho analysis was conducted to analyze the correlation between NLR values and rASRM scores with a significance level of 0.05.

Results

Median of NLR value in the study subjects was 2.03 (1.15–6.15). Patients with a large degree of endometriosis were most commonly reported, with 18 individuals (60%). The correlation coefficient between NLR and rASRM was reported as 0.415 ($p=0.023$). The NLR cutoff was set at ≥ 1.7 .

Conclusions

In conclusion, there is a moderate correlation between NLR and endometriosis severity. However, prospective studies with larger samples are needed to validate the potential of NLR.

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Preoperative Relugolix Combination Therapy in Laparoscopic Myomectomy: Impact on Surgical Planes and Operative Outcomes – A Pilot Study

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Background

Introduction: The introduction of gonadotropin-releasing hormone (GnRH) receptor antagonists in combination therapy has the potential to revolutionise the medical management of uterine fibroids. While its role in symptom control is established, there remains limited evidence on its impact on surgical outcomes, particularly during laparoscopic myomectomy. The aim of this study was to assess the operative effects, both positive and negative, of pretreatment with Relugolix-CT (relugolix-estradiol-norethisterone acetate) on laparoscopic myomectomy compared to no pretreatment. This video presents intraoperative findings of three patients who received Relugolix-CT preoperatively before myomectomy.

Methods

Materials and Methods: We conducted a retrospective analysis of prospectively collected data from patients who underwent a laparoscopic myomectomy over a 6-month period.

Results

Results: A total of 24 patients were included, of which 3 received at least a 3-month preoperative course of Relugolix-CT, and 21 patients received no pretreatment. Blood loss was lower in the Relugolix-CT group (216.6 mL [\pm 189.7]) compared to the no-pretreatment group (354.8 mL [\pm 131.9]), although the difference was not statistically significant ($P = 0.10$). There was no statistically significant difference between the two groups (no pretreatment vs. Relugolix-CT pretreatment) with regard to operating time (148.1 minutes [\pm 16.8] vs. 148.3 minutes [\pm 80.8], $P = 0.99$), and duration of inpatient stay (2.0 days [\pm 0.5] vs. 1.3 days [\pm 1.4], $P = 0.19$). There were no complications in either group. Notably, In 100% of cases with Relugolix-CT pretreatment, no distortion of the fibroid capsule was noted, allowing for complete resection of the fibroids and potentially reducing the risks of recurrence.

Conclusions

Conclusion: Preoperative Relugolix-CT therapy demonstrates benefits in symptom control as well as surgical planning, potentially allowing improved fibroid resection and reduced recurrence risk, without significant adverse effects on operative outcomes. Larger, controlled studies are needed to confirm these findings and explore its impact on minimally invasive surgical outcomes.

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Diagnostic Accuracy of Clinical Diagnosis and Hysteroscopy vs Histopathology in Abnormal Uterine Bleeding with Uterine Cavity Abnormalities at General Hospital Mohammad Hoesin Palembang Indonesia

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Background

Abnormal uterine bleeding (AUB) is a common gynaecological disorder, affecting 33% of reproductive-aged women and 69% in perimenopausal/menopausal women. Diagnosis relies on hysteroscopy, ultrasound, MRI, or histopathology. While histopathology remains the gold standard, hysteroscopy is increasingly used despite its invasiveness and cost. This study aimed to compare the diagnostic accuracy of clinical diagnosis and hysteroscopy against histopathological results in determining the cause of AUB (abnormal uterine bleeding) with structural abnormalities of the uterine cavity.

Methods

Women of reproductive age with abnormal uterine bleeding and structural abnormalities of the uterine cavity that treated with hysteroscopy followed by biopsy for histopathologic examination and not using hormonal contraception or hormonal therapy for at least 3 months at dr. Moh Hoesin Central General Hospital Palembang. A diagnostic test study was conducted on reproductive-age AUB patients who underwent hysteroscopy followed by endometrial sampling at the Department of Obstetrics and Gynecology, Dr. Mohammad Hoesin Central General Hospital Palembang, from January 2012 to December 2015.

Results

The study included 116 subjects admitted to the Obstetrics and Gynecology Department of Dr. Mohammad Hoesin Central General Hospital Palembang. The majority of subjects were aged 30–40 years (52 subjects, 44.8%), with a mean age of 37.84 ± 6.610 years. AUB was most common in multiparous women (63 subjects, 54.3%). Hysteroscopy demonstrated superior diagnostic performance (sensitivity 70.69%, specificity 90.23%, positive predictive value 70.60%, negative predictive value 90.23%, accuracy 85.34%) compared to ultrasound (sensitivity 45.69%, specificity 84.48%, positive predictive value 49.53%, negative predictive value 82.35%, accuracy 74.78%) for diagnosing AUB with structural uterine cavity abnormalities, using histopathology as the gold standard.

Conclusions

Hysteroscopic diagnosis has higher accuracy and agreement with histopathological examination (the gold standard) compared to clinical diagnosis without hysteroscopy. Hysteroscopy outperforms ultrasound (in sensitivity, specificity, predictive values, and accuracy) as a clinical diagnostic modality for AUB with structural uterine cavity abnormalities.

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Relationship between 8-hydroxy-2-deoxyguanosine (8-ohdg) levels in peritoneal fluid and the severity of endometriosis

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Background

Endometriosis is a chronic gynaecological disorder characterized by the growth of ectopic endometrial glands and stroma outside the uterine cavity, and triggers a chronic inflammatory reaction. Inflammatory reactions and oxidative stress are thought to play a role in the process of development and defence of ectopic endometrial implants in the peritoneal cavity so that they can become endometriosis. 8-hydroxy-2-Deoxyguanosine (8-OHdG) is a sensitive indicator of DNA damage due to oxidative stress. Polak et al found higher levels of 8-OHdG in the peritoneal fluid of women with endometriosis. This study aimed to investigate the relationship between the level of 8-hydroxy-2-deoxyguanosine (8-ohdg) in peritoneal fluid and the severity of endometriosis in women undergoing laparoscopic surgery at Dr. Mohammad Hoesin Hospital, Palembang.

Methods

A cross-sectional study was conducted from April to August 2016, involving 42 women diagnosed with endometriosis. following inclusion criteria, 35 participants were selected for analysis after excluding those with non-endometriosis cysts or complications during laparoscopic procedures. 8-ohdg levels were measured using enzyme-linked immunosorbent assay (elisa) at Prodia laboratory, Palembang. statistical analysis was carried out using SPSS version 21.00, applying the Mann-Whitney U test and spearman's rho correlation for data evaluation.

Results

The median age of participants was 30.71 ± 7.01 years, with the majority aged 31-40 years (45.7%). the severity of endometriosis was graded according to the American Society for Reproductive Medicine (ASRM), revealing 8.57% with grade i, 11.43% with grade ii, 40% with grade iii, and 40% with grade iv. the mean 8-ohdg levels significantly increased with higher ASRM grades: grade i (3.97 ng/mL), grade ii (5.63 ng/mL), grade iii (26.28 ng/mL), and grade iv (51.54 ng/mL). significant correlations were found between 8-ohdg levels and the severity of endometriosis in grades ii to iii ($p=0.031$) and iii to iv ($p=0.019$), with a positive correlation coefficient of 0.45.

Conclusions

This study indicates that 8-ohdg levels in peritoneal fluid significantly correlate with the severity of endometriosis, suggesting that oxidative stress plays a role in endometriosis progression. further research is suggested to explore the implications of oxidative stress and potential therapeutic interventions in managing endometriosis.

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Effectiveness of Dienogest and GnRH Agonist Therapy on Antral Follicle Count in Endometriosis Post-Laparoscopic Cystectomy Patients

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Background

Endometriosis affects women of reproductive age and can reduce ovarian reserve after surgery. Medical therapies like GnRH agonists and Dienogest may influence AFC, but their comparative effects post-laparoscopy are unclear. This study aims to compare the impact of Dienogest and GnRH agonist on AFC in women after laparoscopic cystectomy for endometriosis.

Methods

A randomized controlled trial with an open-label design was conducted at dr. Mohammad Hoesin General Hospital Palembang from October 2021 to May 2022. A total of 30 women diagnosed with endometriosis cysts who underwent laparoscopic cystectomy were included. The subjects were randomly assigned to two groups: one receiving Dienogest and the other receiving leuprolide acetate. AFC was assessed at three intervals: pre-operation, 6 weeks post-operation, and 1 month after pharmacological treatment. Comparative analysis was performed using Mann-Whitney and Fisher's Exact tests, while changes in AFC were analysed using Paired T-Test and Wilcoxon tests, with a significance level set at $p < 0.05$.

Results

At 6 weeks post-operation, the average AFC was $6.533 (\pm 1.995)$ for the leuprolide acetate group and $6.200 (\pm 2.274)$ for the Dienogest group, with no significant difference ($p = 0.784$). However, one month after treatment, the leuprolide acetate group showed a significant increase in average AFC (8.200 ± 3.211 ; $p = 0.018$), as did the Dienogest group (7.600 ± 2.667 ; $p = 0.014$). The difference in AFC at this stage between the two treatments was not statistically significant ($p = 0.656$).

Conclusions

Both Dienogest and leuprolide acetate effectively increase AFC in endometriosis patient's post-laparoscopy without significant differences between treatments. This suggests the potential for Dienogest to serve as a viable long-term treatment alternative in this patient population.

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Is it bladder or parasitic leiomyoma?

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Background

Our primary objective is to demonstrate the technique of laparoscopic parasitic leiomyoma excision over the bladder and secondary objective is pay attention to the bladder leiomyoma and parasitic leiomyoma over the bladder.

Methods

The patient was 42 years old G2P2 caesarean deliveries, she had no other surgery. She had no important illness. Her complaints were pelvic pain and heavy bleeding; she had no urinary or other complaints. At bimanual examination, she had mass over the bladder in front of uterus. Transvaginal ultrasound depicted approximately 4*5 cm mass between bladder and uterus. Her endometrial biopsy reported as atypical hyperplasia. Due to completion of fertility desire and atypical hyperplasia pathology report and mass between uterus and bladder, we decided to perform total laparoscopic hysterectomy (TLH) with bilateral salpingectomy (BSJ) and removal of mass.

Results

The operation was uneventful, total operation was 69 minutes. First, we performed hysterectomy and bilateral salpingectomy then removed mass. The important features of the operation were, the location of mass, differentiation of leiomyoma whether parasitic or bladder and the excision. The mass was located over the bladder, when dissection started with opening of the parietal peritoneum, the mass became visible, the mass had no attachment with uterus. To differentiate parasitic leiomyoma located over the bladder and extravesical leiomyoma may be difficult. For definite diagnosis, pathological examination might be needed.

Conclusions

Laparoscopic management of parasitic leiomyoma over the bladder is feasible and reproducible. Preoperative diagnosis between parasitic leiomyoma located over the bladder and extravesical leiomyoma may be challenging.

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Dorsolateral parametrectomy and oophorectomy for deep endometriosis with a suspicious adnexal mass

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Background

Performing surgery for parametrial endometriosis poses many challenges due to uncertainties in standardization, radical surgical methods, and clear surgical indications. Tackling deep-seated endometriosis with a parametrectomy may lead to serious complications, such as postoperative pelvic dysfunction. These issues often arise from unintended damage to, or required removal of, the pelvic ortho- and parasympathetic nervous systems, especially when they are affected by parametrial disease. This video illustrates a laparoscopic procedure for dealing with deeply infiltrating endometriosis, focusing on bilateral dorsolateral parametrectomy. Consent from the patient was obtained for this video demonstration, and the authors report no conflicts of interest.

Methods

A 38-year-old woman, gravida 1 para 1, had been experiencing endometriosis for the past decade. She previously underwent two laparoscopic procedures for endometriosis and a caesarean delivery. She was referred to our gynaecologic oncology clinic due to a suspected adnexal mass. Her symptoms included pelvic and distal vaginal pain, particularly during menstruation. The patient strongly wished to preserve her fertility. MRI findings showed a 70x60 mm hyperdense lesion with mixed solid and cystic components located in the right adnexal region (ORADS-3). Her CA-125 levels were elevated at 290 u/mL, and her ROMA index was 10. A laparoscopic right salpingo-oophorectomy along with bilateral dorsolateral parametrectomy was planned.

Results

The surgery lasted 137 minutes, with a blood loss of 210 mL. The patient was discharged two days post-operation without any complications. Pathological analysis identified atypical ovarian endometriosis and an endometriotic nodule on both dorsolateral parametrium.

Conclusions

Laparoscopic surgery can be successfully performed for deep-infiltrating endometriosis in carefully chosen cases. Combining technique with patience, this approach is especially advantageous for cases with severe adhesions.

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Laparoscopic Oophorectomy for Struma Ovarii: Specimen Extraction via Posterior Colpotomy

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Background

This video presents a case report highlighting an alternative approach for the removal of a large ovarian mass using laparoscopic-assisted posterior colpotomy with endobag protection.

Methods

A 40-year-old woman with no significant personal or family medical history was evaluated for a large left ovarian cyst. Pelvic MRI revealed a complex, multiloculated cystic lesion measuring 80 × 112 × 65 mm with enhancing internal components and no suspicious adenopathy. Thyroid function and tumour markers (CEA, CA-125, and HCG) were within normal limits. Thoracoabdominal CT showed no additional abnormalities. A laparoscopic oophorectomy was planned. Given the cyst's size and indeterminate nature, specimen removal was performed via posterior colpotomy using an endobag to ensure containment. Intraoperative frozen section analysis identified the mass as a Struma Ovarii, and a peritoneal implant was confirmed to be fibrotic connective tissue. Final paraffin histology corroborated the diagnosis. Informed consent for presentation and publication was obtained from the patient.

Results

The surgery was completed without complications. The patient was discharged the following day and experienced an uneventful postoperative recovery.

Conclusions

Posterior colpotomy is a safe and effective technique for the removal of large ovarian specimens during laparoscopy. It avoids the need for enlarging trocar sites or creating additional abdominal incisions while minimizing the risk of intra-abdominal spillage.

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Uncovering The Beyond: Sonographic value for Bowel Endometriosis

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Background

Bowel endometriosis affects up to 37% of patients with known endometriosis and can manifest as superficial or deep infiltrating disease (DIE). In 2016, the IDEA group released a consensus statement on a standardized sonographic protocol to evaluate pelvic pain and endometriosis, outlining four basic components to this assessment. Ultrasound is recommended as first-line imaging as it has sensitivity and specificity for bowel DIE. The objectives of this presentation are to highlight the role of sonography in detecting bowel DIE, showcase three patients with laparoscopic bowel resection for bowel endometriosis, and correlate sonographic, intraoperative, and pathologic findings.

Methods

Patients are evaluated preoperatively at a tertiary academic hospital with high volume endometriosis cases and Minimally Invasive Gynaecologic Surgery (MIGS) and Colorectal Surgery subspecialists. Each patient has a same-day outpatient ultrasound by an experienced sonographer who performs a standardized sonographic evaluation for pelvic pain and endometriosis based on the IDEA consensus protocol. Besides a basic pelvic assessment, additional techniques are performed to evaluate for ovarian endometriomas, adenomyosis, and the anterior/posterior pelvic compartments as well as application of sliding sign on the uterus and adnexa. Based on their sonographic assessment, patients are counselled on a surgical plan and referral to Colorectal Surgery is made if necessary for bowel endometriosis. Consent was obtained from each patient to present and publish their clinical case for educational purposes.

Results

Three symptomatic patients underwent laparoscopic endometriosis resection and a segmental bowel resection and anastomosis after identifying suspected bowel DIE on ultrasound. All patients had resolution of symptoms postoperatively, and sonographic, intraoperative, and pathologic findings correlated well with each case.

Conclusions

Sonography should be used to evaluate for advanced stage endometriosis. A standardized protocol is recommended for optimal surgical planning and excision of endometriosis. Understanding the anatomical relationships between sonographic and operative findings may help improve mapping lesions, and work must continue to train and create accurate and universal descriptions of these operative and sonographic findings.

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Transillumination-Assisted Isthmocele Excision Resulting in Symptom Resolution and Pregnancy

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Background

Isthmocele is a caesarean scar defect that may cause abnormal uterine bleeding and secondary infertility. This video aims to present a laparoscopic isthmocele excision technique assisted by transillumination, highlighting its efficacy in symptom resolution and fertility restoration.

Methods

A symptomatic patient with postmenstrual spotting and secondary infertility underwent laparoscopic isthmocele excision. Transillumination was used via a uterine manipulator to clearly visualize the margins of the niche. The defect was excised, the fibrotic tissue removed, and the myometrial layers were sutured in two layers to restore uterine integrity.

Results

Postoperative follow-up showed complete resolution of abnormal bleeding. The patient conceived spontaneously within one year after surgery, resulting in an ongoing pregnancy.

Conclusions

Transillumination-assisted laparoscopic excision of isthmocele is an effective technique for managing symptoms and improving fertility outcomes. It allows accurate localization of the defect and facilitates safe, anatomically restorative surgery.

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Two-port robotic hysterectomy- Minimising the invasiveness of minimally invasive surgery?

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Background

Background: Two-port robotic-assisted hysterectomy presents a minimally invasive alternative to traditional multi-port techniques. While only a few cases have been reported in the literature [1,2], the enhanced articulation and precision of robotic instruments may facilitate effective surgery through just two access points. Potential benefits include reduced postoperative pain, lower hernia risk, and improved cosmetic outcomes without compromising surgical efficacy.

Objective: To demonstrate the feasibility and versatility of two-port robotic-assisted hysterectomy across different patient scenarios.

Methods

Methods: Three patients were carefully selected based on uterine size, underlying pathology, and surgical history. In the first two cases, the camera port was placed at the umbilicus, with the instrument port in the suprapubic midline. In the third case, the camera was introduced via a left lateral port, with instruments inserted through the umbilicus. A nasogastric tube was inserted through the umbilical incision in all cases to provide suction and irrigation. In Case 2, coexisting endometriosis on the left pelvic sidewall was excised following ureterolysis, aided by vaginal traction using a laparoscopic Manhes.

Results

Results: All procedures were completed successfully without the need for additional ports. Postoperative recovery was uncomplicated in all cases, with rapid discharge from hospital, early return to normal activities, excellent cosmetic outcomes, and complete resolution of presenting symptoms.

Conclusions

Conclusion: Two-port robotic-assisted hysterectomy is a feasible and effective approach for selected cases, even when minor incidental pathology is encountered. This technique offers a promising evolution in minimally invasive gynaecologic surgery. Further research is needed to assess its generalisability and long-term outcomes.

References:

1. Mauricio D, Webster EM, Harold J, et al. Two-port robotic laparoscopic hysterectomy. *J Minim Invasive Gynecol.* 2021;28. <https://doi.org/10.1016/j.jmig.2021.09.315>

2. Moawad GN, Tyan P, Khalil EDA. Two-port robotic hysterectomy: A novel approach. *J Robot Surg.* 2018;12. <https://doi.org/10.1007/s11701-018-0797-2>

<https://player.vimeo.com/video/1083862800?autoplay=1>

Vaginal Prolapse of a Cervical Myoma in a Virgin Patient: A Rare Case Report

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Background

A young patient with severe anaemia due to vaginal prolapse of cervical myoma underwent surgery. This case highlights the diagnostic and therapeutic challenges presented by unusual presentations particularly those complicated by virginity, a cultural factor in some communities.

Methods

A 24-year-old woman with severe anaemia secondary to persistent vaginal bleeding. However, a standard vaginal examination could not be performed due to cultural sensitivities related to virginity. The patient consulted the gynaecology outpatient clinic several times with the same complaint but faced difficulties in reaching a definitive diagnosis. Consequently, she was referred to the gynaecological oncology clinic for pelvic mass, where magnetic resonance imaging (MRI) was requested. The MRI showed a sizable (54 x 41 x 43 mm) mass in the vaginal area that was compressing the rectum and not distinct from the cervix. Simultaneously, the patient had ongoing vaginal bleeding resulting in severe anaemia. In view of the MRI findings, oncologists emphasized biopsy to exclude malignancy. Since the patient's history was a virgin, hysteroscopic biopsy would be the optimal method. Nevertheless, vaginal prolapsed fibroid was diagnosed intraoperatively by hysteroscopy, with resultant choice to proceed with total myomectomy. The patient provided informed consent for publication and presentation.

Results

The hysteroscopic myomectomy was performed, resulting in the effective removal of the prolapsed myoma without immediate complications. There was a normal uterine cavity with patent tubal ostia and no residual pathology on postoperative assessment. The postoperative course of the patient was uneventful. These results highlight the effectiveness of hysteroscopic myomectomy for prolapsed myomas. Al-Shukri et al. Investigated the difficulties and considerations in the surgical management of large prolapsed submucous myomas. With their study, they reveal that the vaginopedal characteristics of the myoma also play a significant role in the success of surgical intervention, suggesting that it should not only be emphasized the size of the myoma, but also the number of myomas, the length and thickness of the pedicle (1). Furthermore, as seen as the present case, cervical leiomyomas need to be prioritized because of the rare but severe complications they can cause like abnormal uterine bleeding, pelvic pain, and very occasionally prolapse and cervical inversion (2).

Conclusions

This case highlights the need for tailoring treatment strategies on an individual level, especially when anatomical or social factors may affect decisions regarding diagnostic and therapeutic approaches. Proper use of preventive measures before complication occurrence has shown to be effective in avoiding complication to severe anaemia disease as well as improving recovery outcome.

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Minihysteroscopy and Robotic-Assisted Surgery: Advancing Diagnosis and Treatment in Endometrial Cancer

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Background

Abnormal uterine bleeding (AUB) accounts for over 70% of complaints in peri- and post-menopausal women. While the majority of cases are related to benign conditions approximately 10% are associated with premalignant or malignant pathologies, including endometrial carcinoma. Until now, the recommended tool for diagnosing AUB has been endometrial sampling. It is still mostly done by dilation and curettage (D&C), which is a blind procedure with an estimated effectiveness of 30%. Modern procedures such as hysteroscopy give an effectiveness of diagnosis and treatment at the level of 90%

Methods

We present a case of a 61-year-old patient with 3cm submucosal fibroid (FIGO type 1) and a two-year history of AUB. She had previously undergone two D&C procedures, both yielding benign histopathological findings. Following the failure of hormonal treatment, she was proposed to do myomectomy or simple hysterectomy. We suggested to do minihysteroscopy in local anesthesia of cervix (hysteroblock) before any therapeutic decisions.

Results

During hysteroscopic evaluation, the patient was diagnosed with endometrial carcinoma with a sarcomatous component. The procedure not only facilitated accurate diagnosis after previous inconclusive assessments but also effectively controlled the bleeding, allowing timely completion of staging investigations. The patient was classified with early-stage disease (FIGO I) and underwent robotic-assisted surgery. This approach contributed to an improved postoperative course and enabled prompt initiation of adjuvant chemotherapy, significantly impacting the patient's prognosis.

Conclusions

Minihysteroscopy offers superior diagnostic accuracy and therapeutic utility, particularly when conventional methods such as blind curettage fail. Combined with robotic-assisted surgery, it exemplifies the shift towards modern, patient-centred strategies in the management of endometrial cancer. We advocate for the replacement of outdated techniques — such as blind curettage and open radical hysterectomy — with more precise and less invasive modalities

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Modern minihysteroscopy Under Local Anaesthesia for Large Intrauterine Tumours

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Background

Endometrial polyps are the most common cause of abnormal uterine bleeding (AUB), affecting approximately 25% of women of reproductive age. While typically benign, the risk of malignant transformation increases to 7–8% in postmenopausal women, particularly those with risk factors such as advanced age, nulliparity, obesity, diabetes mellitus, hypertension, polycystic ovary syndrome, or other forms of hormonal dysregulation. In some cases, polyps can grow to significant sizes, rendering traditional diagnostic and therapeutic approaches—such as dilation and curettage (D&C)—ineffective.

Methods

We present two cases of postmenopausal women with suspected endometrial hyperplasia or large endometrial polyps. Both had a history of multiple D&C procedures, which failed to resolve their symptoms. Instead, we opted for office-based minihysteroscopy under local cervical anaesthesia (hysteroBLOCK), utilizing modern 15 French instruments: a miniresectoscope and a mechanical tissue removal device.

Results

Minihysteroscopy enabled efficient and well-tolerated removal of large intrauterine lesions without the need for general anaesthesia. In the miniresectoscopy case, the main challenge was extracting the large polyp without cervical dilation; usually the lesion needs to be fragmented and removed piecemeal. In the second case, the mechanical tissue removal device facilitated simultaneous morcellation and aspiration, simplifying the process and reducing operative time. The use of local anaesthesia improved the safety profile of the procedure, particularly in patients with comorbidities, and both individuals reported being pain-free throughout.

Conclusions

Office minihysteroscopy using miniaturized resectoscopy and tissue removal systems is a safe, effective, and well-tolerated approach for the management of large intrauterine tumors. These techniques eliminate the need for general anaesthesia and cervical dilation, offering a particularly valuable alternative for older patients or those with comorbidities and are much more effective than traditional D&C procedures.

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Discussion of all findings of hysteroscopic perforation with video presentation

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Background

Hysteroscopy is a minimally invasive endoscopic procedure. It plays a crucial role in the evaluation and management of infertility, particularly in identifying and correcting structural anomalies. Hysteroscopy is associated with a risk of complications, which have been reported in approximately 0.2% to 10% of cases. Uterine perforation is among the major complications. It most commonly occurs during cervical dilatation but may also arise during the operative phase of the procedure.

This video presentation will demonstrate the hysteroscopic findings, diagnosis, and management of a previous uterine perforation identified in a patient who was referred to our centre after an uncompleted hysteroscopy

Methods

A 22-year-old patient, married for two years, had previously been diagnosed with a complete uterine septum. During an attempted hysteroscopic septum resection at another centre, the procedure was discontinued due to prolonged operative time and a malfunction in the imaging system. The patient was referred to our centre 20 days later for completion of the procedure. On examination, a partial uterine septum was observed, along with a 10 mm hyperechoic area in the right uterine cavity. Local institutional review board approval was not required for this video because the patients were not identified.

Results

Following cervical dilation, the resectoscope was advanced into the uterine cavity. Intrauterine pressure was adjusted to 80–100 mmHg, and septum resection was initiated. The tubal ostium on the left side was visualized, while a blood clot was noted in the right cavity. Upon reaching the midpoint of the procedure, the following events occurred in sequence:

A decrease in intrauterine pressure led to the collapse of the uterine cavity.

A deterioration in image quality was observed.

Diffuse bleeding into the cavity began from vessels within the incised septum.

The roller pump of the endomat started operating at high speed, delivering excessive saline into the uterine cavity.

Abdominal distension began to develop.

A perforation site and the right ovary were visualized behind the clot in the right cavity.

Inflammation and granulation tissue were observed at the site of perforation.

An old perforation was observed in the fundal area of the right cavity. The septum incision was halted midway, and bleeding sites were cauterized. The outer sheath of the hysteroscope was advanced through the perforation site into the abdominal cavity to drain the accumulated fluid. It was then understood that the previous procedure performed at another centre 20 days earlier had been terminated due to this perforation. Three months later, the patient underwent reoperation under low pressure, during which the residual septum was excised.

Conclusions

Uterine perforation is one of the major complications of hysteroscopy. Prompt recognition and evaluation of clinical findings are crucial for timely diagnosis. Early identification helps prevent further deterioration of the complication.

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Ureteral Vascularization and perfusion check with Indocyanine Green

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Background

in pelvic surgeries we face the risk of ureteral injuries and this possibility increases in complex surgeries.

The advance of near infrared fluorescence techniques and equipments nowadays gave us more one tool to increase surgical safety.

The "ureteral painting" (intraluminal injection of Indocyanine green dye (ICG) through cystoscopy)" is a good technique to plot the ureter in complex cases but we could go far.

In this video with some surgical cases, we show the evolution of that technique from the ureteral perfusion check to real time video angiographies using Near Infrared laparoscopic cameras.

It's important to emphasize that we could combine techniques and the initial ureteral painting don't prohibit the use of both techniques during the surgery.

Methods

Video collection and explanation about ureteral injuries in laparoscopy surgeries with examples of use of Fluorescence techniques to check the perfusion and ureteral vascularization with the endovenous injection of ICG during the surgery

Results

The use of ureteral painting technique with low dosage of Indocyanine Green Dye, generally, in the beginning of the surgery, don't prohibit the use fluorescent video angiography during the surgery.

Conclusions

The use of fluorescence techniques to check perfusion and vascularization of the ureter could improve surgical safety, allowing the detection of injuries during the surgery.

it could also be combined with ureteral painting technique generally performed in the beginning of the procedure.

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Fluorescent Endoluminal Coated Devices

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Background

After a brief review of fluorescence assisted surgeries, we propose a new technique to increase safety during surgeries.

Bladder injuries during laparoscopic hysterectomy due to poor visualization or distorted anatomy because due to fibrosis from endometriosis, previous infections, previous surgeries like caesarean deliveries.

The bladder injuries could be reduced with proper visualization of the colpotomiser of the uterine manipulator.

So, we proposed a new technique to enhance his observation during surgeries using fluorescent techniques.

Methods

Minutes before the surgery the border of disposable uterine manipulator was painted with fine mixture of Indocyanine Green Dye and Surgical Glue and wait to be dried.

The uterine manipulator was inserted accordingly during the setup for the surgery.

During the procedure, as needed, the fluorescence overlay mode on laparoscopic camera was turned on, helping identify the boundaries of the colpotome of the uterine manipulator.

Results

The improved visualization of the colpotome helps during the surgery.

Conclusions

The use of a fluorescent coated colpotomizer could improve safety of that surgery.

It's a simple, fast, safe and low-cost way to coat a endoluminal instrument with Indocyanine Green Dye helping identify limits for the colpotomy despite the fog using monopolar hook.

That technique could be applied in other endoluminal devices like circular staplers and probes.

<https://player.vimeo.com/video/1084604794?autoplay=1>

Complex laparoscopic hysterectomy in a patient with prior abdominal mesh and antiplatelet therapy: surgical feasibility and technique considerations

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Background

We aimed to demonstrate the technical feasibility and challenges of laparoscopic hysterectomy in a high-risk patient with prior abdominal mesh repair, cardiovascular comorbidities, and obesity.

Methods

A 40-year-old woman (G3P2A1) with a history of one caesarean section and two incisional hernia mesh repairs was scheduled for total laparoscopic hysterectomy and bilateral salpingectomy due to abnormal uterine bleeding (AUB-L, FIGO PALM-COEIN classification). Her medical history included hypertension, valvular heart disease with arrhythmia, chronic smoking, and a BMI of 36. She was on low-dose aspirin (100 mg/day), which was discontinued five days preoperatively. ICU and transfusion backup were arranged. Due to anterior abdominal wall mesh extending below the umbilicus and a narrow vaginal canal, a laparoscopic approach was selected. Access was gained via the Lee Huang point, with the camera later shifted to Palmer's point. The surgery was performed under low-pressure pneumoperitoneum (10–11 mmHg) and limited Trendelenburg positioning.

Results

The total operative time was 155 minutes. During specimen detachment, bleeding from the right uterine artery occurred, likely due to insufficient occlusion. This was successfully managed laparoscopically. Vaginal cuff closure was performed transvaginally to avoid prolonging operative time. Haemoglobin decreased by 2.8 g/dL postoperatively. The patient was managed with enhanced recovery after surgery (ERAS) protocols and discharged uneventfully after 40 hours with PACU support.

Conclusions

This surgery was performed during the learning curve of a non-expert surgeon and two obstetrics and gynaecology residents, who had previously completed a total of 55 laparoscopic procedures, including 16 total laparoscopic hysterectomies. The case emphasizes the critical importance of proper patient selection and procedural planning for novice endoscopic surgeons. We strongly recommend that complex cases be approached in collaboration with experienced and expert surgeons to enhance patient safety and surgical outcomes. Additionally, in anatomically distorted fields, early proximal ligation of the uterine arteries at the level of the internal iliac vessels may aid in controlling intraoperative bleeding.

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Navigating the vascular maze: managing uterine arteriovenous malformations

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Background

Uterine arteriovenous malformations (AVMs) are rare. Despite their associated risk of life-threatening haemorrhage, there are no standardized treatment algorithms. The objective of the video is to review AVMs and the management options. We will then present our institution's approach to a laparoscopic hysterectomy for a large AVM at a tertiary care center in Toronto, Canada.

Methods

After reviewing the literature on AVMs, we present the case of a healthy 26-year-old G2P2 with two previous C-sections and no other uterine instrumentation. She presented multiple times to the emergency department with significant vaginal bleeding that failed conservative management. Further investigation revealed a large AVM on MRI, with a peak systolic velocity of 150 cm/s on ultrasound. In alignment with the patient's goals, the decision was made to proceed with definitive management via laparoscopic hysterectomy.

Results

We present our stepwise pre-operative planning along with intra-operative considerations. We emphasize the use of interventional radiology tools as intra-operative adjuncts. We then present our surgical approach to securing blood flow to the AVM and our bladder dissection technique to minimize risk of AVM disruption. The patient recovered well and was discharged home on postoperative day one.

Conclusions

In conclusion, hysterectomy is a reasonable management option for a large AVM if aligned with the patient's goals and represents the only safe option in cases of hemodynamic compromise. We present our approach to pre- and intra-operative considerations to maximize safety in hysterectomy for definitive management of AVMs.

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When fighting, use all your weapons!

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Background

Hysteroscopic tools have remarkably improved over the last years.

The introduction of new tools, like the Integrated Bigatti Shaver (IBS) system, has enabled easy management of endometrial cavity abnormalities, such as thickened endometrium, polyps and myomata.

Methods

We present a case of a 41years old, who is married since 2021. She has had a previous 1 CS. She was seeking fertility, following a 3-year period of secondary infertility. She went for ICSI in 2023, but failed. In 2024, she had a second trial, where 9 oocytes were taken and 4 embryos were returned, resulting in no pregnancy.

Results

Combined hysteroscopy and laparoscopy were decided for her. Adhesions were observed at the Anterior abdominal wall, with right tubal distal block with adhesions. Tubes became patent and healthy after adhesiolysis and right tubal irrigation with an antibiotic. On hysteroscopy, easy entry was done with a trans cervical approach. On inspection of the uterine cavity, thickened hypertrophic endometrium was observed. Behind this thickened endometrium, uterine septum was discovered.

Visualisation and, consequently, excision, of the uterine septum was technically impossible with this thick, bleeding endometrium. An idea of getting rid of this troublesome endometrium, and then excising the septum came to mind, so that the patient can have all the necessary steps performed in one go.

We proceeded with the Integrated Bigatti Shaver (IBS) system to remove the abnormally thickened endometrial lining until it was restored back to the normal limit. Then, a change of instruments to the operative hysteroscope with scissors was performed, and the septum was easily excised, now that vision is improved and bleeding minimised.

Conclusions

Different hysteroscopic tools can be combined sequentially in one setting to enable the management of all encountered abnormalities in one session, sparing the patient the need for multi-session treatment.

This should be performed under strict monitoring of the patients' vitals, with a special focus on fluid balance.

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A 10-Year Cerclage!

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Background

Cerclage is commonly performed procedure, which can be of significant benefit in the well-selected patients.

Cerclage is often removed during CS, or when the patients go into labour.

Methods

We hereby present the case of a 34 year old lady came to our centre complaining of secondary infertility for 10 years, She was a P1+1, who delivered twin babies by C-section. Her menstrual cycle was irregular; she menstruates every 2 months and her period lasts for 4 days. However, it was scanty.

Ultrasound showed Pancake kidneys, while the uterus was reported to be distended with blood (hematometra)

Additionally, a blood-filled mass was seen at the lower part of the uterus, and was suspected to be either a chocolate cyst, or a non-communicating uterine horn!

Results

Combined hysteroscopy and laparoscopy were decided for her. On laparoscopy, omental adhesions were found and dissected from the anterior abdominal wall. Also, the uterus was adherent to the abdominal wall, and was dissected.

However., it was a normal uterus, with no non-communicating horns identified.

On vaginal examination, and after grasping the cervix, entry failed due to severe cervical stenosis. On vaginoscopy trying to inspect the cervix, an old rust-stained tape was noticed

Navigation around the cervix revealed old cerclage tape, left since her previous pregnancy 10 years ago!!

The tape was held by a forceps, and cut off the cervix where it was deeply impeded. Entry through cervix was then done with drainage of a large amount of altered blood out from the cervix and uterus.

The cervix was found to be markedly dilated into a large barrel-shaped cavity, even larger than the uterine cavity itself. After complete drainage, the external os was dilated up Heggar's number 6.

The patient's symptoms remarkably improved during follow up, and her menses are not painful anymore.

She is given a chance to conceive spontaneously for up to 12 months

Conclusions

Cerclage is commonly performed procedure, which can be of significant benefit in the well-selected patients.

Cerclage is often removed during CS, or when the patients go into labour.

Sometimes, cerclage removal is forgotten, especially in emergency CS, but this can have lifelong impacts on the patients' reproductive health.

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A Shaver for the Virgin!

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Background

Despite well-recognised advantages of resection, several problems, such as fluid overload, uterine perforation due to unipolar or bipolar current, lack of visualization resulting in a time-consuming procedure, and a long learning curve, remain still unsolved.

Additionally, the wide diameter of the resectoscope, even the recently introduced mini-resectoscope, render it less suitable for use in nulliparous patients as well as patients who wish to keep the integrity of their hymen due to various reasons

Methods

We hereby report our approach to deal with a 19 years old virgin patient, who has irregular menstrual cycle and Heavy Menstrual Bleeding (HMB)

She has received several courses of haemostatic and hormonal treatments, but with no improvement in her symptoms or bleeding pattern

She had menarche was at 13 years, and she was medically and surgically free

Ultrasound examination showed thick irregular endometrium (16 mm), and multiple small size follicles likely PCO

The patient was counselled for hysteroscopy.

Of note that the patient was a virgin, and due to the cultural importance of the hymen, the patient was very keen on keeping the virgo intacta status. So, the shared decision was for vaginoscopic hysteroscopy, through the hymenal orifice.

Results

Diagnostic hysteroscopy revealed that the endometrium was thick with polypoidal pattern and high vascularity

Because grasping the cervix, and performing a dilatation and curettage, which is needed in for this pathology, would result in breakage of the hymen, we thought a different approach was needed.

Trans-hymen operative hysteroscopy with Integrated Bigatti Shaver (IBS) was inserted, trimming of the thickened endometrium was performed.

After completion of the procedure, the Hymen was re-examined, and was found intact

The patient experienced remarkable improvement of her symptoms, and was cured of the HMB

Conclusions

Despite well-recognized advantages of resection, several problems, such as fluid overload, uterine perforation due to unipolar or bipolar current, lack of visualization resulting in a time-consuming procedure, and a long learning curve, remain still unsolved.

Additionally, the wide diameter of the resectoscope, even the recently introduced mini-resectoscope, render it less suitable for use in nulliparous patients as well as patients who wish to keep the integrity of their hymen due to various reasons

Thus, the IBS system seems to be a suitable alternative in such patients, where it permits most operative procedures in hysteroscopy to be safely and effectively performed.

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Nerve-Sparing Robotic Management for Deep Infiltrating Endometriosis with Uterosacral and Ureteric Involvement

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Background

Deep infiltrating endometriosis (DIE) involving the uterosacral ligaments and ureter often leads to severe pelvic pain, dyspareunia, and potential compromise of urinary tract function. Surgical excision aims not only to remove disease but also to preserve autonomic pelvic nerves to maintain organ function and quality of life. This video demonstrates a nerve-sparing robotic approach for complex DIE.

Methods

A 35-year-old woman with chronic pelvic pain and severe dysmenorrhea underwent robotic surgery for DIE involving the left uterosacral ligament and ureter. After retroperitoneal access, the ureter was mobilized, and the endometriotic lesion was excised en-bloc while carefully preserving the hypogastric nerve and inferior hypogastric plexus. The dissection was guided by anatomical landmarks and intraoperative nerve identification.

Results

The total operative time was 140 minutes with minimal blood loss. The ureter was successfully decompressed and preserved. No intraoperative or postoperative complications occurred. The patient experienced significant pain relief and reported preserved bladder and bowel function postoperatively. At 6-month follow-up, no recurrence was observed, and quality-of-life scores improved.

Conclusions

Robotic nerve-sparing surgery is a feasible and effective option in the management of DIE involving the ureter and uterosacral ligaments. Precise dissection allows complete excision of disease while preserving pelvic autonomic nerves, resulting in favourable functional and symptomatic outcomes.

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Robot-assisted laparoscopic hysterectomy based on membrane anatomy

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Background

Membrane anatomy (MA) is a surgical operation theory based on the embryonic development of tissues and organs. The key step of MA is to identify the correct space between adjacent organs and fascia by antagonistic traction during the operation. According to membrane anatomy, the operation is always carried out in the correct surgical space and has little bleeding and clear surgical field, which reduces the risk of organ injury and tumour recurrence. Huge uterine fibroids may encounter difficulties in traditional laparoscopic surgery, including the fibroids affecting the surgical field, and the difficulty of stripping and suturing due to the location of uterine fibroids. The high-definition vision and wrist operating instruments of the Da Vinci robotic system can cope with these difficulties well.

Methods

We performed robot-assisted laparoscopic hysterectomy based on membrane anatomy for a patient with giant uterine fibroids and excessive menstruation and secondary anaemia.

Results

Although the huge uterus made it difficult to expose uterine vessels and ureters during the surgery, the operation went smoothly and took 62 minutes. The estimated operative blood loss was about 20 ml. The patient recovered well after operation without surgical complications.

Conclusions

The application of membrane anatomy in robot-assisted laparoscopic hysterectomy has the advantages of reducing surgical bleeding, reducing organ damage and accelerating postoperative rehabilitation.

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Intraureteric Indocyanin Green in Laparoscopic Endometriosis Surgery 10 Steps

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Background

To demonstrate a step-by-step technique of intraoperative intraureteric indocyanine green (ICG) administration under cystoscopic guidance to localize the ureters under near-infrared fluorescence imaging during laparoscopic surgery for deep endometriosis

Methods

The standardization and description of the procedure are presented in 10 steps

Results

A patient diagnosed with deep endometriosis underwent laparoscopic surgery. Ten main steps of cystoscopy with intraureteric ICG administration, allowing real-time visualization of the ureters during adhesiolysis and endometriosis resection, were described in detail:

Step 1 – Preparing ICG Step 2 – Preparing the ureteric catheter Step 3 – Preparing instruments for cystoscopy Step 4 – Performing cystoscopy Step 5 – Identifying the ureteric orifices Step 6 – Inserting the ureteric catheter through the ureteric orifices Step 7 – Injecting ICG Step 8 – Performing laparoscopic surgery Step 9 – Intraoperative visualization of the ureters Step 10 – Resection of deep endometriosis

Conclusions

Cystoscopy-guided intraureteric ICG dye instillation combined with intraoperative near-infrared fluorescence imaging is a safe and effective technique. It allows precise, real-time visualization of the ureters, making the procedure faster and easier while reducing the risk of intraoperative ureteric complications during laparoscopic surgery for deep endometriosis.

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<https://player.vimeo.com/video/1119848484?autoplay=1>

Ovarian Cystectomy, it's all about the technique!

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Background

Ovarian cysts are a frequent encounter in minimally invasive surgery (MIS), and in gynaecological practice in general. There are many different types of cysts, including:

- simple,
- haemorrhagic
- dermoid
- endometriotic
- dermoid
- inflammatory
- neoplastic (benign and malignant)
- other types

Management strategies for such ovarian cysts are dependent on their nature, in addition to the clinical context. Among the management strategies are expectant management, medical treatment, guided-aspiration, ablation or excision.

Excision of the cyst wall is the ultimate solution to totally get rid of the disease. However, it comes at a cost. Patients who are keen on keeping their fertility potential often present a decision challenge for the minimally invasive gynaecological surgeon (MIGS).

In such patients, delicate balance has to be maintained between the aim to eradicate the disease, and the hope of maintaining ovarian reserve. Cystectomy, especially for dermoid and endometriotic cyst has a bad reputation of causing a detrimental effect on ovarian reserve.

However, this is a false allegation in our view

Methods

In these examples of cyst excision, we demonstrate different techniques of cystectomy, where we tried to achieve the balance of radicality with the disease, and preservation with the reserve.

The key to achieving this is through identifying the correct plane of separation between the cyst wall and the surrounding ovarian tissue.

Even with the most adherent of cysts, there still remains a cleavage plane, which should be targeted.

Careful dissection, after identifying this plane, with a special attention to preserving each bit of ovarian tissue, should then follow.

Results

With follow up of these patients, in whom we have implemented these techniques, we have not observed any significant post-operative decline of markers of ovarian reserve, mainly AMH levels. Contrarily, many of the cases we followed up managed to achieve spontaneous pregnancy within a year of surgery.

Additionally, clinical relapse of symptoms, and recurrence of the cysts were minimal, even with longer follow up

Conclusions

Observing a delicate technique during performing ovarian cystectomy, especially in patients keen on keeping their reproductive potential, can achieve the holy grail of radically excising the disease, while maintaining the precious reserve of oocytes in the ovary.

The key to achieving this target is meticulous identification of the plane of cleavage, and then proceeding with delicate separation of tissues, not sparing any efforts to preserve ovarian tissue.

The final outcome of this diligent procedure seems favourable, not only on the patients' reproductive potential, but also on the remission periods from the disease.

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Scope Adhesiolysis!

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Background

Abdominal adhesions are common after operations involving all abdominal organs. Fortunately, most adhesions never cause any problems. But if there is signs of a potential bowel obstruction, like abdominal pain or trouble passing gas, the surgical intervention may be needed.

Repeated abdominal surgery is one of the one of the most challenging situations in Endoscopic surgery.

In our centre we have a cumulative experience in adhesiolysis especially for women with history of multiple laparotomies. Laparoscopic entry is the most dangerous step, 50% of Endoscopic surgery complications occurred during entry.

Primary entry is always a blind step, thus, with the presence of dense adhesions at the entry site, the minimally invasive gynaecologic surgeon (MIGS) may find the scope inside the adhesions themselves.

Methods

We demonstrate a technique we have been using in many cases, where dense adhesions are encountered, no matter where the primary port is placed. This scenario is encountered in patients with previous supra-umbilical exploratory incisions, or with previous peritoneal infection.

In such patients, access for the secondary ports cannot be performed due to the severity of adhesions.

In these cases, we have developed a manoeuvre where the scope itself is used as a blunt dissector. Following the bubbles caused under the effect of insufflation forcing the CO₂ into the areolar tissues, and while visualising the viscera, the scope can be carefully advanced into the planes of cleavage between the adherent bowel loops and the abdominal wall.

This manoeuvre is pursued until a clearance is made for secondary port insertion is achieved.

Results

Learning from a large cohort of patients with complex past surgical history, and extensive intra-operative adhesions, we managed to modify and master this useful manoeuvre of "scope adhesiolysis", that we believe comes to rescue when such complex cases are encountered.

The complications of bowel injury or major bleeding have been minimal over the years of expertise with this technique.

Conclusions

We believe that this manoeuvre of using the scope as a blunt dissector, under vision, is both safe and effective in navigating difficult surgical fields, in patients with complex surgical history and murky operative fields.

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vNOTES retroperitoneal uterosacropexy using the semitendinosus tendon

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Background

While several minimally invasive techniques have been established for prolapse repair, sacral suspension remains the gold standard due to its anatomical correct fixation and high success rates. Due to several restrictions associated with MESH implantation, several techniques using native tissue repair have been developed. The HoTT procedure developed by Horneman et al. implanted the semitendinosus tendon laparoscopically for sacral fixation of the uterus. Vaginal approaches are associated with faster recovery and reduced postoperative pain. However, standard vaginal surgery offers limited access to the sacral promontory. Vaginal Natural Orifice Transluminal Endoscopic Surgery (vNOTES) expands surgical possibilities by allowing access to the sacrum via the vaginal route. In this technique, vNOTES is utilized to perform a sacral fixation through a retroperitoneal corridor with the semitendinosus tendon.

Methods

To demonstrate a novel minimally invasive technique for central compartment prolapse repair using the semitendinosus tendon via a vaginal retroperitoneal approach.

- 1 Dissect half of the semitendinosus tendon
- 2 Prepare tendon for sacropexy
- 3 Anterior colpotomy and dissection of the anterior cervix
- 4 Posterior colpotomy and blunt dissection of pararectal space
- 5 Longitudinal incision of anterior longitudinal ligament
- 6 Fixation of the semitendinosus tendon through the anterior longitudinal ligament
- 7 Bring both tendon ends via a paracervical route to the anterior cervix
- 8 Tie both tendon ends over the anterior cervix and elevate the uterus
- 9 Close colpotomy

Results

vNOTES semitendinosus tendon uterosacropexy was performed with minimal blood loss and without any intra- and postoperative complications. Surgical steps are illustrated in the video.

-

Conclusions

This novel retroperitoneal vNOTES approach enables anatomically correct, minimally invasive prolapse repair of the central compartment using the semitendinosus tendon. It combines the benefits of native tissue sacral fixation with the advantages of a vaginal route, including reduced postoperative morbidity and expedited recovery.

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Atypical clinic of ovarian torsion: Can increase of stromal oedema only predict the ovarian torsion in case without any loss of vascularization?

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Background

Ovarian torsion is an emergent situation for generally reproductive aged women, related on twisting of ovary on the tissues supporting it. The main symptoms are abdominopelvic pain, nausea, vomiting; following to necrosis peritonitis, fever and abnormal vaginal bleeding. The character of pain can be sharp and stabbing or dull and crampy. It can be located to lower abdomen or spreading to thighs, flank and lower back. Therefore, distinguishing from other emergencies can be challenging. The symptoms can be intermittent due to twisting-untwisting circle. Ovarian mass longer than usual ovarian ligaments, pregnancy and fertility treatments increase the risks. Transvaginal ultrasound detects no blood flow to ovary but exact diagnose is with surgery and seeing the twisting.

Methods

The patient applied to emergency service with right-side pelvic pain. She didn't have any adnexal mass history. Transvaginal ultrasound couldn't be applied due to be sexually inactive. Computed tomography (CT) in emergency service showed pelvic fluid and reported as suspicion of cyst rupture. During, the hospitalization, the ovarian vascularisations via abdominal ultrasound were maintaining. Haemoglobin level was stable. The pelvic pain was intermittent. Following the frequent ultrasounds even there was vascularisation, the stromal oedema started to be significant. Magnetic Resonance Imaging (MRI) demonstrated unilateral enlargement of ovary. After the council with radiologists, the preliminary diagnosis was ovarian torsion. The ovary was observed three times twisted and larger but there was no change of colour in the operation and detorsion was conducted. The regression of ovarian oedema was observed in postoperative ultrasound.

Results

In ovarian torsion cases, early diagnose is pivotal to protect ovaries. During the follow-ups, the painless periods and maintaining complete vascularization caused to wait for operation. Measurements of haemoglobin level and ultrasound controls provided to detect stromal oedema as excluding cyst rupture.

Conclusions

Ovarian torsion can present with different clinics especially with unexplained pelvic pain in reproductive ages. This case showed that if there is intermittent pelvic pain even there is vascularization of the ovaries, ovarian torsion should be kept in mind and the operation shouldn't be delayed surviving ovaries.

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Surgical Video Presentation: Comprehensive Laparoscopic Approach to Multisite Deep Infiltrating Endometriosis with Bowel and Appendiceal Involvement

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Background

To present a stepwise laparoscopic surgical approach for the treatment of complex deep infiltrating endometriosis (DIE) involving the rectosigmoid colon, bilateral ovaries, uterosacral ligaments, and appendix in a patient with a history of infertility.

Methods

This surgical video demonstrates the laparoscopic management of a 44-year-old woman with a history of infertility, prior pelvic infection requiring hospitalization post-hysterosalpingography, left salpingectomy, and a failed in vitro fertilization (IVF) attempt. Imaging and clinical evaluation revealed bilateral endometriomas, adenomyosis, and deep infiltrating endometriosis with bowel involvement. Key surgical steps included thorough pelvic exploration, retroperitoneal dissection, bilateral ureterolysis, excision of uterosacral ligament nodules, extensive adhesiolysis, and complete excision of endometriotic implants. Additional procedures included right salpingectomy, excision of a right ovarian endometrioma, left oophorectomy due to abscess formation, ileocecal resection, and appendectomy for appendiceal endometriosis. Segmental resection of the rectosigmoid colon with primary anastomosis was performed for DIE nodules. The right ovary was temporarily suspended using the T-lift technique to optimize surgical field exposure. Anastomotic integrity was verified using air and saline leak tests. Haemostasis was secured, and a pelvic drain was placed at the end of the procedure.

Results

The procedure was successfully completed laparoscopically without intraoperative complications. Normal pelvic anatomy was re-established following the release of dense adhesions and resection of DIE lesions. The postoperative course was uneventful.

Conclusions

This video highlights a systematic and meticulous laparoscopic approach for the management of extensive DIE involving multiple pelvic and gastrointestinal structures. Restoration of normal anatomy through precise dissection and systematic surgical planning is vital to optimizing surgical outcomes.

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A novel approach: Laparoscopically assisted vaginal myomectomy along with the use of endoloop for a large pedunculated FIGO Type 0 fibroid

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Background

Aim

To demonstrate a novel hybrid technique for the management of large and highly vascular fibroid FIGO Type 0.

Case

38-year-old patient, nulliparous, presented with recurrent episodes of heavy vaginal bleeding requiring blood transfusion along with voiding difficulty. On examination there was evidence of large mass occupying the vagina. Further investigations with transvaginal and transabdominal scan demonstrated a large Type 0 fibroid with a thick stalk arising from the uterine fundus. The patient could not tolerate GnRH analogues.

Methods

The procedure started with diagnostic laparoscopy where 20mls of diluted Argipressin(20iu/ml) - 0.9% NaCl in a ratio 1:19, were injected into the myometrium near the fibroid stalk in order to minimise blood loss with vasoconstriction. The bladder was obviously distended despite an indwelling catheter which confirmed the mass effect of the fibroid on the bladder neck. We followed vaginally by passing an endoloop around the fibroid and advancing it to the stalk of fibroid before tightening it up. Knife morcellation and complete resection of the fibroid with minimal blood loss was performed. A further endoloop was applied on the remaining fibroid stalk for further haemostasis and the stalk was pushed back in the uterus. The last step in our procedure was to check the uterus laparoscopically in order to ensure we didn't cause uterine inversion or any other injury. The patient was discharged home on the same day with an indwelling catheter.

Results

Minimal blood loss. At her first follow up visit, the patient had an uneventful recovery and resolution of her symptoms. The histopathology results showed benign leiomyoma.

Conclusions

This hybrid approach combining laparoscopy to inject vasopressor agents along with the help of an endoloop can improve blood loss and reduce complication rates in vaginal myomectomies for highly vascular fibroids.

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Fluorescence-Guided Single-Port Robotic Nerve-Sparing Surgery for Deep Endometriosis Using Indocyanine Green

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Background

Nerve-sparing surgery for deep endometriosis (DE) has been shown to reduce postoperative voiding dysfunction. However, performing such procedures in cases with severe adhesions and fibrosis requires advanced surgical expertise and has traditionally been limited to expert surgeons. As endometriosis is a common condition, intraoperative identification of endometriotic lesions, ureters, vessels, and nerves using near-infrared imaging with indocyanine green (ICG) has been explored to facilitate safer surgeries by a broader range of surgeons. In parallel, the da Vinci SP (SP), a newer single-port surgical robot, has been introduced to enhance the cosmetic outcomes and reduce invasiveness in laparoscopic procedures. This video presents a step-by-step demonstration of a novel combined approach using SP for nerve-sparing DE surgery guided by ICG fluorescence.

Methods

A 25-mm vertical umbilical incision was made for insertion of the SP access port, accommodating a camera and three articulating instruments. ICG (0.25 mg/kg) was intravenously administered during critical phases: nerve plane separation, lesion identification, and assessment of pelvic organ integrity and haemostasis.

Results

22 patients underwent nerve-sparing modified radical hysterectomy and complete excision of DE lesions with ICG navigation using the SP system. The mean operative time was 146 minutes, and the estimated blood loss was 10 mL. All procedures were completed without complications. Postoperative recovery was uneventful, with no cases of bladder or rectal dysfunction. Histopathological examination confirmed DE or fibrosis in all resected specimens. Patients reported high satisfaction due to minimal pain and inconspicuous scarring.

Conclusions

Nerve-sparing DE surgery using the SP system is technically safe and feasible, offering cosmetic advantages. The integration of ICG near-infrared fluorescence imaging may enhance intraoperative decision-making and broaden the applicability of this advanced procedure.

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Laparoscopic pectopexy without use of polypropylene mesh

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Background

Vaginal vault prolapse is a common complication in women undergoing hysterectomy because hysterectomy can worsen pelvic floor dysfunction. Surgical treatment options for vaginal vault prolapse include vaginal, abdominal, laparoscopic and robotic approaches to move the vaginal vault into the anatomically correct position, providing support using natural tissue or, in some cases, synthetic mesh. The importance of minimally invasive surgery in the treatment of vaginal vault prolapse has increased due to the potential benefits of the laparoscopic procedure. Pectopexy is a current, easy-to-perform operation that has been used in the treatment of prolapse, allowing a laparoscopic approach and preserving the woman's normal anatomy.

Methods

The 66-year-old patient, who has a history of four vaginal births, a BMI of 26 and comorbidities such as diabetes mellitus and hypertension, underwent vaginal hysterectomy and sacrospinous fixation two years ago due to the indication of pelvic organ prolapse. Using a laparoscopic approach, the anterior wall of the vaginal cuff was dissected, the bladder was retracted and the location of the left iliopectineal ligament was determined. Using a hammock-like technique, the anterior wall of the vaginal vault was suspended to the lateral side of the left iliopectineal ligament (Cooper's ligament) without tension, with a size 0 non-absorbable suture that we passed under the lateral umbilical ligament. The prolene node was covered with peritoneum. The operation time was 40 minutes, and the patient was discharged without complications on the 2nd postoperative day.

In the current video, we present laparoscopic pectopexy without mesh for vaginal vault prolapse after hysterectomy.

Results

Laparoscopic pectopexy without mesh offers several advantages over traditional open surgery, such as shorter recovery time, less amount of bleeding and less postoperative pain. This technique also eliminates the use of synthetic mesh, reducing the risk of complications associated with mesh implants such as erosion, infection and pain.

Conclusions

Laparoscopic pectopexy, performed without the use of polypropylene mesh, has shown to be an effective method for the correction of apical prolapse. This technique may be particularly beneficial for patients with poorly controlled diabetes mellitus, as it avoids potential complications associated with synthetic mesh use, while still providing reliable support and symptom relief. The procedure offers a promising alternative for those seeking minimally invasive options, especially in cases where mesh-related risks are of concern.

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Steps of laparoscopic extraperitoneal para-aortic lymphadenectomy in an endometrial cancer patient with morbid obesity

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Background

Staging surgery is critical in the treatment of endometrial cancer. Minimally invasive approaches can provide great advantages in surgical interventions that become difficult due to obesity. The extraperitoneal approach is a convenient and safe alternative to laparoscopic para-aortic lymphadenectomy. This video demonstrates the steps of extraperitoneal para-aortic lymphadenectomy in an endometrial cancer patient with morbid obesity.

Methods

A 53-year-old female patient with a body mass index of 37.2 kg/m² applied with the complaint of postmenopausal bleeding. After the patient's gynaecological examination, a diagnostic endometrial biopsy was performed. Since the result was grade 2 endometrial adenocarcinoma, the patient underwent pelvic MRI, upper abdominal and thoracic CT evaluation before surgery. MRI showed a mass measuring 35*25*22 mm with deep myometrial invasion. No pathological lymph nodes were observed. Additionally, there was no pathological evidence of lymph node or lung metastasis on CT. Preoperative CA125 value was 21. Based on these findings, staging surgery was planned for the patient. Laparoscopic extraperitoneal pelvic lymphadenectomy, para-aortic lymphadenectomy, laparoscopic hysterectomy without the use of manipulators, and bilateral salpingo-oophorectomy operations were performed. No evidence of extra-uterine macroscopic disease was seen at the time of surgery.

Results

The operation time was 289 minutes, and the patient was discharged without complications on the 3rd postoperative day. Surgical pathology was reported as grade 2 endometrial carcinoma with less than 50% myometrial invasion without serosal invasion. Pelvic lymphadenectomy revealed 16 nodes without neoplastic infiltration. A total of 24 para-aortic nodes were removed and there was no neoplastic infiltration.

Conclusions

The extraperitoneal approach facilitates surgery by creating a surgical field independent of the intestine and can provide more effective removal of lymphatic metastases thanks to direct access to para-aortic lymph nodes. Choosing a minimally invasive approach in gynaecological oncological surgery, especially in obese patients, can minimize the risk of wound infection, accelerate the patient's recovery process, and allow early initiation of adjuvant treatment.

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Laparoscopic Management of a Giant Type 5 Leiomyoma

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Background

This video demonstrates a stepwise laparoscopic total hysterectomy combined with bilateral salpingectomy in a 50-year-old female patient referred for surgical treatment of a large symptomatic uterine myoma. The patient reported progressively worsening dysmenorrhea and chronic pelvic pain over the preceding three months, culminating in severe discomfort that significantly impacted her daily functioning and quality of life.

Methods

A minimally invasive laparoscopic approach was selected to optimize perioperative outcomes and minimize surgical morbidity. The procedure included systematic trocar placement, detailed dissection of pelvic anatomical landmarks, controlled ligation of uterine and tubal vasculature, and removal of the uterus and fallopian tubes. The vaginal cuff was closed laparoscopically. High-definition surgical footage is presented with comprehensive intraoperative narration to enhance educational value and promote technique standardization.

Results

The operation was completed successfully without intraoperative complications. The specimen, including a markedly enlarged myomatous uterus and both fallopian tubes, was extracted transvaginally. The patient had an uneventful recovery and was discharged on postoperative day one.

Conclusions

This case exemplifies the expanding role of laparoscopic surgery in the management of high-volume myomatous uteri. Despite the considerable size of the pathology, total hysterectomy with bilateral salpingectomy was accomplished via a fully laparoscopic approach, reinforcing the capacity of minimally invasive surgery to address complex gynaecologic cases once reserved for laparotomy. The outcome underscores the clinical and educational value of advanced laparoscopic techniques in modern gynaecologic practice.

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The management of intrinsic unilateral ureteral hydronephrosis related to deep infiltrating endometriosis: A case report with the adhesiolysis of ureter by laser

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Background

Endometriosis is the ectopic growth of endometrial tissue outside the uterine cavity. It is classified into three categories: superficial peritoneal endometriosis, deep infiltrating endometriosis (DIE), and ovarian endometriomas. Infertility is a common presentation of endometriosis, with DIE being the most severe form. Ureteral involvement is observed in approximately 9–23% of DIE cases. We present the case of a 36-year-old woman with infertility and unilateral ureteral hydronephrosis due to DIE, managed with laparoscopic ureterolysis using laser energy.

Methods

A 36-year-old woman presented with infertility and left lumbar pain. She had a history of two previous laparoscopic surgeries for endometriosis. Given the clinical suspicion of stage IV and deep infiltrating endometriosis along with hydronephrosis, pelvic and urinary tract ultrasound was performed. The imaging revealed bilateral large ovarian endometriomas, kissing ovaries, a nodule between the cervix and rectum, and moderate left-sided hydronephrosis. A subsequent contrast-enhanced abdominal CT scan confirmed these sonographic findings.

Results

The patient was scheduled for laparoscopic surgery. A diagnostic ureteroscopy performed at the beginning of the procedure revealed ureteral stenosis, and the catheter could not initially be advanced into the ureter. Following laparoscopic laser ureteral adhesiolysis, successful catheterisation was achieved. The surgery included excision of the ovarian endometriomas and nodulectomy at the rectosigmoid junction due to intestinal DIE involvement. Following the operation, the patient underwent frozen embryo transfer (FET) and achieved a live birth.

Conclusions

Hydronephrosis related to deep infiltrating endometriosis is rare but can lead to serious renal damage due to delayed diagnosis. Clinicians should maintain a high index of suspicion, especially in patients with atypical symptoms. Early diagnosis is critical for favourable outcomes. Laparoscopic ureterolysis using laser technology is a viable and effective management option in such cases.

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Feasibility and surgical outcome of robotic-assisted excision of ureteric endometriosis, presenting with significant hydronephrosis and requiring segmental ureteric resection and anastomosis

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Background

Objective To demonstrate the feasibility and surgical outcome of robotic-assisted excision of ureteric endometriosis, presenting with significant hydronephrosis and requiring segmental ureteric resection and anastomosis

Methods

A 36-year-old woman presented to the endometriosis clinic with chronic pelvic pain, dyspareunia, dyschezia, urinary frequency, recurrent urinary tract infections, and secondary subfertility. MRI revealed a left ovarian endometrioma adherent to the left ureter, causing proximal hydroureteronephrosis. A MAG-3 renogram showed a capacious left collecting system with sluggish but satisfactory drainage. Following multidisciplinary team (MDT) discussion, a robotic approach was planned, including endometriosis excision, left ovarian cystectomy, ureterolysis, cystoscopy, and intraoperative ICG injection/stenting.

Results

Intraoperatively, cystoscopy with ICG injection was performed. Left ureteric catheterization was unsuccessful due to resistance; ICG highlighted only the distal ureter. Robotic dissection revealed a dilated ureter with a clear transition point. ICG was not visualized beyond this point, further supporting a diagnosis of functional obstruction. A urologist performed segmental ureteric resection followed by primary end-to-end anastomosis. The left ovarian endometrioma was drained and excised. The patient had an uneventful recovery and is awaiting follow-up imaging and functional assessment.

Conclusions

Ureteric endometriosis is a rare but potentially silent condition, affecting 0.1–1% of endometriosis cases, and may lead to irreversible renal damage if not promptly recognized. Cross-sectional imaging and renal functional studies are crucial for diagnosis. In this case, dense fibrosis and extrinsic involvement necessitated segmental resection rather than ureterolysis. Robotic assistance provided enhanced visualization and precise dissection in a complex anatomical field, facilitating safe excision and reconstruction. A surgical video accompanying this abstract further illustrates the key operative steps and anatomical considerations.

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Intraoperatively preventing L5-S1 presacral haemorrhage associated with laparoscopic sacropexy

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Background

Laparoscopic sacropexy is a reliable and minimally invasive procedure for pelvic organ prolapse, comparable to open abdominal sacropexy. However, in elderly patients, the downward shift of the aortic bifurcation can reduce the available space between the great vessels and the anterior longitudinal ligament of the L5–S1 disc, increasing the risk of presacral haemorrhage. As preoperative vascular imaging is not routinely performed, such anatomical variations may be unexpectedly encountered during surgery.

Methods

This video presents a stepwise surgical demonstration from a regional hospital affiliated with a tertiary care centre, highlighting the anatomical challenges and operative strategy in an aging woman undergoing laparoscopic sacropexy. Under general anaesthesia and lithotomy positioning, the presacral region was dissected with a harmonic scalpel to identify the anterior longitudinal ligament. Key vascular structures, including the middle sacral vein and bilateral common iliac vessels, were visualized. Upon encountering limited presacral space and appreciating the risk of vascular injury, the surgical plan was converted intraoperatively to a laparoscopic pectopexy.

Results

Dissection revealed significant downward displacement of the aortic bifurcation, resulting in inadequate space for safe mesh placement. The procedure was safely transitioned to a laparoscopic pectopexy without complication. The alternative approach allowed effective pelvic organ suspension while avoiding potential presacral haemorrhage.

Conclusions

In elderly patients, age-related vascular descent may compromise the safety of sacropexy by reducing the presacral workspace. Intraoperative identification of anatomical constraints and readiness to adapt the surgical plan—such as conversion to pectopexy—can reduce the risk of major complications. Surgeons should maintain a high index of suspicion for vascular variation and consider alternative laparoscopic techniques to ensure patient safety and surgical success.

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Minimally Invasive Burch Colposuspension: A Safe and Effective Approach for Stress Urinary Incontinence

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Background

Stress urinary incontinence (SUI) is a prevalent condition among women, particularly those with multiple vaginal deliveries or weakened pelvic floor support. The Burch colposuspension remains a well-established surgical treatment for SUI, aiming to elevate and stabilize the urethra by suspending the anterior vaginal wall to the Cooper's ligaments. The laparoscopic approach offers a minimally invasive alternative, with reduced morbidity and faster recovery, while preserving the effectiveness of the traditional open technique.

Methods

A laparoscopic Burch colposuspension was performed on a 50-year-old woman presenting with clinically confirmed stress urinary incontinence and no prior pelvic surgeries. After establishing pneumoperitoneum and appropriate trocar placement, the Retzius space was carefully dissected by entering between the obliterated umbilical arteries. The bladder was retracted to expose the bilateral Cooper's ligaments.

Non-absorbable sutures were placed through the paraurethral endopelvic fascia approximately 1.5–2 cm lateral to the midurethra and anchored to the ipsilateral Cooper's ligament bilaterally, ensuring symmetrical elevation and minimal tension. Two sutures were placed on each side.

Following secure suspension and haemostasis, the peritoneum overlying the bladder was closed. Intraoperative cystoscopy was performed to confirm urethral integrity and bilateral ureteral patency via visualization of jet flow from both orifices.

Results

The procedure was completed successfully without any intraoperative complications. Adequate suspension of the urethra was achieved bilaterally with symmetrical suture placement and secure fixation to the Cooper's ligaments. Haemostasis was confirmed, and peritoneal closure was performed.

Intraoperative cystoscopy demonstrated an intact urethra, no evidence of bladder injury, bleeding, or hematoma, and bilateral ureteral jet flow, confirming preservation of ureteral function.

Conclusions

Laparoscopic Burch colposuspension represents a safe and effective surgical option for the treatment of stress urinary incontinence in women. This technique offers the benefits of minimally invasive surgery while maintaining the anatomical efficacy of the open procedure.

The video highlights critical anatomical landmarks, surgical steps, and safety considerations, serving as a valuable educational tool for gynaecologic surgeons seeking proficiency in pelvic floor reconstructive procedures.

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Opportunistic Apical Support by Reusing Pre-existing Lateral Suspension Mesh During Laparoscopic Surgery for Bilateral Adnexal Masses

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Background

Reoperative laparoscopic surgery in patients with prior pelvic floor repair requires careful planning, particularly when apical support is needed. We present a case of laparoscopic bilateral adnexal mass excision in which apical uterine support was opportunistically restored by reusing a pre-existing lateral suspension mesh.

Methods

A 52-year-old postmenopausal woman (G3P3) with a history of laparoscopic lateral suspension and Muscovitz sutures (2021) presented with pelvic pressure, bilateral adnexal masses, and stage 2 enterocele. POP-Q examination revealed an apical defect (C: 0, D: -2). Transvaginal ultrasound showed a 77×69 mm dense cystic mass in the left adnexa compressing the bladder and a 32×30 mm cyst in the right ovary. No free fluid was seen. Pelvic MRI confirmed bilateral thick-walled T1/T2 hyperintense cystic lesions, suspicious for mucinous neoplasms. Tumour markers (CA 125: 4, CEA: 1.27, AFP: 8) and Pap smear were within normal limits. The patient underwent laparoscopic bilateral salpingo-oophorectomy, enterocele repair, perineoplasty, and opportunistic uterine refixation to the existing lateral suspension mesh using non-absorbable sutures placed through the anterior uterine wall and round ligaments.

Results

The previously placed mesh was intact and effectively reused for bilateral uterine refixation. Adhesiolysis was performed to mobilize the adnexa, and both ovarian cysts were excised and removed via endobag. Histopathology confirmed bilateral endometrioid cystadenomas. The surgery was completed without complications. Postoperative POP-Q evaluation showed significant improvement in apical support: point C shifted from 0 to -5 and point D from -2 to -6, indicating effective uterine suspension. Recovery was uneventful.

Conclusions

This case highlights that during reoperative pelvic surgery, existing lateral suspension mesh can be safely and effectively reused for opportunistic apical uterine support. This mesh-preserving, minimally invasive strategy provides a valuable option in complex secondary pelvic floor procedures.

<https://player.vimeo.com/video/1085455819?autoplay=1>

Ureteral intrinsic endometriosis: diagnosis and surgical treatment with robotic assistance strategy

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Background

Ureteral involvement is a rare manifestation of endometriosis and occurs in only 0.1% of women. It is classified as extrinsic, which affects the ureteral adventitia, and intrinsic, which is defined as invasion of the ureteral muscle. Ureteral endometriosis is under-diagnosed most of the time.

MRI is useful in cases of ureteral endometriosis, being more sensitive than surgery, but less specific to diagnose intrinsic disease. The confirmation of intrinsic endometriosis often requires ureteroscopy which provides direct visualization of the ureter and a biopsy for a pathologic diagnosis. The optimal choice of management for ureteral endometriosis has not been well established due to its rarity. Bibliography suggests ureteral resection is indicated for intrinsic ureteral lesions. For distal ureteral lesions, ureteroneocystostomy is the traditional choice of management because ureteroureterostomy is associated with a higher complication rate

Methods

A case of a 39-year-old patient is presented describing the diagnostic sequence and the surgical management under the suspicion of intrinsic ureteral endometriosis. Stepwise demonstration of the surgical technique with narrated video footage.

Results

The video footage describes a robot-assisted laparoscopic management of ureteral intrinsic endometriosis with ureteral reimplantation. The surgery is synthesized in the following steps:

1. Pelvis exploration and dissection of avascular spaces.
2. Dissection of the normal ureter proximal and distal to the implant.
3. Resection of the diseased ureter confirming intrinsic affection.
4. Hysterectomy
5. Mobilization of the bladder, cystostomy and spatulation of the ureter cut-end.
6. Reimplantation of the ureter

Conclusions

Ureteral intrinsic endometriosis is a rare presentation of endometriosis. It can be suspected on MRI; however, the confirmation diagnosis is made by ureteroscopy. The most successful treatment for these cases is a ureteral resection. Our experience shows the feasibility and efficacy of a robot-assisted laparoscopic approach for this rare situation.

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vNOTES hysterectomy with bilateral salpingo-oophorectomy for huge bilateral adnexal masses

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Background

Adnexal masses are a frequent gynaecological concern for women across all age groups, with approximately 10% needing adnexal surgery throughout their lives. When addressing benign ovarian tumours, laparoscopic adnexectomy is favoured over laparotomy due to its reduced surgical trauma, fewer postoperative complications, lower levels of postoperative pain, and shorter duration of hospitalization. Evaluating the features of an adnexal mass before undergoing surgery is vital. To avoid cyst rupture and abdominal spillage in cases where masses possess a moderate to high malignancy risk (O-RADS 4 or 5), a laparotomy might be required. However, larger adnexal masses presumed to be benign can be effectively extracted through minimally invasive methods.

Methods

A 58-year-old patient with a history of two caesarean deliveries presented with a pelvic mass causing significant daily pain and a mass effect. During the pelvic exam, two soft, non-tender, and movable masses were noted in the midline, extending above the umbilicus. A CT scan revealed simple unilocular cysts originating from both ovaries, measuring 18x12 cm and 7x5 cm, with no nodularity or septations. CA125: 25 U/mL. A vNOTES hysterectomy and BSO were completed successfully. A Frozen Section revealed benign masses on both sides. The surgery was completed without any perioperative complications, and the patient experienced a smooth postoperative recovery. The procedure is demonstrated in the accompanying video.

Results

The patient returned home on the first day after surgery without any noticeable incisions. The final pathology report verified the diagnosis of bilateral serous cystadenoma.

Conclusions

vNOTES is an innovative minimally invasive technique that can effectively address suitable adnexal conditions. By integrating laparoscopic and vaginal surgical methods, this approach offers several added advantages, such as improved visualization, quicker recovery, and the absence of visible incisions.

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**Surgical failure of hysteroscopic resection after uterine artery embolization in a figo type 2 myoma:
A case-based video presentation**

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Background

A 41-year-old woman with a six-year history of infertility and prior hysteroscopic myomectomy (2018) followed by uterine artery embolization (UAE) in 2020 was referred to our centre in 2023. Transvaginal ultrasonography revealed a FIGO type 2 intramural-submucosal myoma compressing the endometrial cavity from the anterior uterine wall, along with additional fibroids at the fundus and posterior corpus. Hysterosalpingography demonstrated bilateral tubal obstruction and an unclear endometrial contour.

Methods

Hysteroscopic myomectomy was planned to remove the residual myoma. Intraoperatively, necrotic fibroid tissue resulting from the prior UAE could not be resected with electrosurgical instruments, despite using high-voltage energy. Consequently, the procedure was converted to mini-laparotomy for complete myoma excision. The endometrial cavity was accessed, an intrauterine device (IUD) was inserted, and combined oestrogen-progestin therapy was initiated postoperatively.

Results

Due to decreased menstrual flow, an office hysteroscopy was performed three months later. After serial oestrogen therapy and second-look hysteroscopies, the endometrial cavity was deemed suitable for embryo transfer. The patient was subsequently enrolled in an IVF program.

Conclusions

This case illustrates the limitations of hysteroscopic electrosurgery in resecting necrotic fibroids after UAE and emphasizes the risk of intrauterine adhesions in patients undergoing repeated uterine interventions. Postoperative management strategies, including hormonal support and anti-adhesive measures, are essential to optimize reproductive outcomes.

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Total vNOTES for adnexal surgery in case of a difficult access to the posterior vaginal cul-de sac: a video demonstration

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Background

vNOTES uses the vagina as the surgical channel for endoscopy and achieves improved cosmesis compared to conventional laparoscopy. vNOTES is the only surgical approach that allows adnexal procedures to be performed while preserving the uterus and leaving no abdominal scars. When access to the posterior vaginal fornix is challenging, performing the standard incision by classic vaginal route may carry a significant risk of complications. This video aimed to demonstrate the concept of the total vNOTES technique, which involves performing the incision under pneumovaginoscopy to enable safe and controlled entry when access to the posterior vaginal fornix is challenging.

Methods

Stepwise demonstration of the technique with narrated video footage.

Results

The following key steps was performed:

- (1) Clinical examination under general anaesthesia
- (2) vNOTES pot introduction
- (3) Posterior colpotomy under pneumovaginoscopy
- (4) Repositioning of the vNOTES port into the peritoneal cavity
- (5) Bilateral salpingectomy
- (6) Vaginal closure by vaginoscopic guidance and CO2 exsufflation

Conclusions

This case demonstrates the total vNOTES technique as a reliable and safe alternative for adnexal surgery when access to the posterior fornix is limited. With excellent visualization and no abdominal scars, this technique expands the possibilities of minimally invasive vaginal surgery.

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Neurolysis of the Ilioinguinal Nerve leading to Complete Resolution of Chronic Neuropathic Pain Symptoms. Demonstration of Robotic Nerve Detrapment and Anatomy.

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Background

Robotic-assisted neurolysis is an innovative, minimally invasive technique for managing chronic nerve entrapments and neuropathic pain in the lower abdomen and groin. Chronic neuropathic pain in this region may be implicated in post-surgical and idiopathic pain syndromes, such as those following inguinal hernia repairs or laparoscopic procedures but may also be affected by infiltrating endometriosis.

Methods

We present a case of a 36-year-old female with a 15-year history of persistent neuropathic pain in the right groin, with progressive symptoms on the left. Her complex surgical history included eight abdominal procedures, the most recent being a total hysterectomy and bilateral salpingectomy, followed by bilateral oophorectomy and excision of endometriosis from the round ligaments, all undertaken to address her pain. Despite intermittent symptom relief—notably during pregnancies, following dorsal root ganglion stimulation at the L1-L2 level, and GnRH agonist treatment—most significant relief was achieved with a temporary genitofemoral and ilioinguinal nerve block.

Results

In this video, we provide a detailed anatomical review of the lumbar plexus, with particular focus on the genitofemoral and ilioinguinal nerves, demonstrating their spatial relationships to surrounding structures via robotic-assisted laparoscopic dissection. The ilioinguinal nerve, a critical component in transmitting sensory input from the lower abdominal wall, inguinal region, and upper medial thigh, was found to be compressed by a vascular structure in this patient. Through careful dissection, we identified and ligated the offending vessel, leading to immediate and complete resolution of the patient's neuropathic pain symptoms postoperatively.

Conclusions

Traditional approaches to nerve decompression, including open or conventional laparoscopic surgery, are often associated with significant morbidity, prolonged recovery, and inconsistent outcomes. This case highlights the advantages of robotic-assisted neurolysis, including enhanced three-dimensional visualisation, superior magnification, precise dissection, and wristed articulation, which allow for safer, more meticulous nerve decompression.

As robotic surgery continues to evolve, its application in the treatment of chronic pelvic and groin pain syndromes is likely to expand. Our findings reinforce the potential for robotic-assisted neurolysis

to serve as a viable and effective alternative to traditional nerve decompression methods. Further research is warranted to assess long-term outcomes and establish standardised surgical protocols for optimising patient selection and procedural success in the management of neuropathic pain caused by nerve entrapment.

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Butterfly Excision of Peritoneal Endometriosis

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Background

Peritoneal endometriosis can cause debilitating pelvic pain and infertility, even in early-stage disease. Surgical excision remains the gold standard for symptom relief and disease control. The purpose of this video is to demonstrate the butterfly excision technique—a precise, reproducible method for the treatment of superficial peritoneal endometriosis that prioritizes complete lesion removal, preservation of healthy tissue, and protection of critical pelvic structures.

Methods

This video illustrates a laparoscopic butterfly excision in a patient with symptomatic superficial peritoneal endometriosis. The lesions involved the bilateral pelvic sidewalls, peritoneum overlying the ovarian fossae, and uterosacral ligaments. After careful inspection of the pelvis, a bilateral, fan-shaped dissection was performed around each lesion. This created two symmetrical "wings" of peritoneal tissue resembling a butterfly, allowing en bloc excision of the affected area. The dissection was carried out using cold scissors and bipolar energy to maintain clear tissue planes, minimize thermal spread, and ensure meticulous haemostasis. Special attention was given to preserving the ureters, uterine arteries, and hypogastric nerves, and to avoiding excessive traction or devascularization of adjacent structures.

Results

The butterfly excision technique enabled full-thickness removal of peritoneal lesions with minimal intraoperative blood loss and without the need for conversion to a more extensive approach. Key anatomical landmarks were well visualized throughout, and the pelvic nerves and vessels were successfully preserved. The patient had an uncomplicated recovery, was discharged the same day, and reported significant improvement in pain at her six-week follow-up. Histology confirmed endometriosis with clear margins.

Conclusions

The butterfly excision technique offers a structured and nerve-sparing approach to the surgical management of peritoneal endometriosis. It facilitates safe, complete excision with minimal disruption to surrounding structures and is especially useful in cases of multifocal or bilaterally distributed disease. This method is reproducible, efficient, and suitable for use in both general and specialized endometriosis surgical practice. Incorporating this technique may enhance surgical outcomes, reduce recurrence, and improve quality of life for patients with peritoneal endometriosis.

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Bladder dissection in the presence of uterovesical dense adhesions in total laparoscopic hysterectomy surgery

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Background

Bladder dissection in the presence of uterovesical dense adhesions in Total Laparoscopic Hysterectomy surgery

Total Laparoscopic Hysterectomy (TLH) is frequently preferred by many physicians today. Caesarean section rates have tended to increase all over the world in last decades due to multiple reasons. The number of women who have had a caesarean section and undergone hysterectomy is also increasing day by day. The risk of urinary system injury and perioperative complications during hysterectomy increases in women who have had a previous caesarean section. Bladder mobilization and creation of the uterovesical space are important stages during the hysterectomy procedure. If adhesion occurs between the uterus and bladder due to previous caesarean delivery, the risk of bladder injury increases.

Methods

In this video presentation, I will present our approach to bladder adhesiolysis cases in TLH operations at our academic tertiary centre with videos. During all dissections, the uterus is pushed as far cranially and posteriorly as possible. In the presence of adhesion and fibrotic tissue, bladder dissection is basically performed in two ways.

1- Central approach: Fibrotic adhesive tissues dissected layer by layer from cranial to caudal until an appropriate dissection plane is found.

2- Lateral approach: If the hard fibrotic tissue is densely adherent between the bladder and uterus anteriorly, the areolar tissue just below the fibrotic area is dissected laterally to reach the vaginal fascia. The fibrotic tissues remaining cranial from the close distance to the uterus are excised.

Results

A total of 8 bladder dissection videos is presented. First video shows the basic bladder mobilisation technique, 7 of which demonstrate dissection of dense adhesions.

1. Case 39Y P2 VD BRCA positivity
2. Case 38Y P2 CS Atypic Hyperplasia
3. Case 62Y P2 VD CS ovarian cyst
4. Case 40Y P1 CS Adnexal mass
5. Case 49Y p2 CS Myoma

7. Case 47Y p2 CS Myoma

8. Case 44Y P3 CS Endometrioma

Conclusions

In cases of severe bladder adhesion, it is possible to perform bladder dissection without complications using appropriate surgical technique.

<https://player.vimeo.com/video/1085629383?autoplay=1>

Case Report: V-NOTES Salpingectomy and Chromopertubation

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Background

Ectopic pregnancy is a common gynaecological emergency in women of reproductive age. Early diagnosis and follow-up allow for appropriate evaluation of medical or surgical treatment options. In this case report, we present a patient who was initially managed medically but subsequently underwent a V-NOTES salpingectomy due to a right-sided hydrosalpinx.

Methods

A 29-year-old woman (G1P0) with no known comorbidities presented with lower abdominal pain. Her initial serum β -hCG level was 1056 mIU/mL. Two days later, the level decreased to 826 mIU/mL and continued to decline over the following four days (581 \rightarrow 487 mIU/mL).

Transvaginal ultrasonography showed no free fluid in the pouch of Douglas, and both ovaries were within normal limits. Histopathological examination revealed no placental tissue. As her symptoms regressed, the patient was discharged approximately one week after her initial presentation.

Over the following week, serial β -hCG levels continued to decrease (436 \rightarrow 375 mIU/mL). However, the patient was readmitted the next day with recurrent lower abdominal pain and was hospitalized with a presumptive diagnosis of ruptured ectopic pregnancy. Examination revealed limited areas of coagulation. As her hemodynamic status remained stable, conservative management was pursued. She was discharged approximately four days later.

β -hCG levels were monitored over the subsequent four weeks, eventually declining to near-zero levels. About three weeks after this point, pelvic MRI revealed a 56×60 mm multiseptated, contrast-enhancing cystic lesion adjacent to the right ovary, suggestive of a right-sided hydrosalpinx.

Approximately eight months after her initial presentation, the patient was readmitted for elective surgery. A V-NOTES right salpingectomy with chromopertubation was performed without complication. The postoperative course was uneventful, and she was discharged on the same day.

Histopathological examination confirmed chronic nonspecific salpingitis and hydrosalpinx.

Results

Although some ectopic pregnancies resolve with medical treatment, persistent symptoms and radiological findings in selected cases may necessitate surgical intervention. In this case, the V-NOTES (vaginal natural orifice transluminal endoscopic surgery) technique was used safely and effectively, offering the benefits of minimally invasive surgery.

Conclusions

Post-ectopic pregnancy tubal pathologies may require surgical management. vNOTES salpingectomy is a safe and effective treatment option in appropriately selected patients.

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Laparoscopic Identification of the Inferior Hypogastric Nerve for the Gynecologist

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Background

To demonstrate how to identify and preserve the inferior hypogastric nerve during gynaecological laparoscopic surgeries, in cases where the nerve is not infiltrated by pathological processes such as deep endometriosis. The inferior hypogastric nerve is liable to injury during gynaecological surgery, which may lead to vaginal and cervical hypoesthesia, diminished vaginal lubrication, urinary retention or anorectal dysfunction.

Methods

Narrated surgical video. Institutional Board Review approval not required, patient consent obtained. 40-year-old patient with chronic pelvic pain. Imaging suggested the presence of a 4-centimeter right haemorrhagic cyst. No evidence of deep endometriosis was detected on imaging or laparoscopy. Excision of the Douglas pouch peritoneum confirmed the presence of superficial endometriosis. The patient was scheduled for laparoscopic removal of the haemorrhagic cyst and excision of peritoneal endometriosis.

Results

We focus on the patient's left side: Initially, a superficial incision is made on the peritoneum, at the level of the ureter crossing the left common iliac vessels. Using blunt and sharp dissection, the ureter is mobilized carefully, with its vascular supply intact, and pushed laterally, off the posterior leaf of the broad ligament. The inferior hypogastric nerve is located two centimetres below and parallel to the ureter, in the meso-ureter, and 2 centimetres superior and parallel to the uterosacral ligament. To identify and preserve its fibres, following ureterolysis, the peritoneum is lifted at the level of the pelvic brim and dissection continued superficially and caudally, until the fibres of the inferior hypogastric nerve are visualized (**Figure 1**). In cases of peritonectomy for superficial peritoneal endometriosis, the nerve can be fully visualised and kept intact, by gently pushing its fibres off the affected peritoneum that will, subsequently, be excised. Having lateralized the inferior hypogastric nerve, blunt dissection is continued medially to the nerve, until the left uterosacral ligament is identified medially to it. Should the ligament also need to be excised, it can be done safely with minimal risk of injuring the nerve.

Conclusions

Preservation of the inferior hypogastric nerve is feasible and reproducible by following the surgical steps described here.

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Pregnancy After Hysteroscopy-Guided Laparoscopic Repair Of Cesarean Scar Defect : A Case Report

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Background

To report a successful pregnancy outcome after hysteroscopy-guided laparoscopic repair of a Caesarean Scar Defect (CSD) and to describe the 6-step surgical procedure.

Methods

case report

Results

Mrs.28-year-old female, parity one, presented to Nunukan General Hospital with a chief complaint of postmenstrual spotting for the last two years. Her menstrual cycles had been regular during this period, however she occasionally experienced spotting three days after the cessation of menstruation. Two years prior, the patient had consulted an obstetrician-gynaecologist, and an ultrasound examination revealed a defect in her caesarean scar. She was advised to be caution regarding a subsequent pregnancy due to the thinness of the scar. Her obstetric history included a primary caesarean section for her first child due to active phase labour dystocia. Subsequently, she experienced one miscarriage, which was not managed by curettage. The patient expressed a desire for another pregnancy and had not used any form of contraception for two years. Pelvic examination revealed a uterus of normal size and shape. Cervical inspection showed a smooth cervix, with no abnormal discharge or active bleeding. Transvaginal ultrasound demonstrated a normal-sized uterus and adnexa, with a caesarean scar defect measuring 6.2 mm in width and a significantly thin residual myometrial thickness (RMT) of 1.2 mm.

Hysteroscopy-guided laparoscopic CSD repair was performed. The procedure involved the following 6 steps: Anatomical survey by inspection and palpation, mobilization of the bladder and development of the vesicovaginal space, hysteroscopic illumination to confirm the boundaries of the isthmocele, haemostatic control, excision of the abnormal uterine scar tissue, re-approximation of the lower uterine segment.

The patient was discharged two days post-procedure. Eight months later, she presented at 6 weeks of gestation and was advised to attend regular antenatal check-ups. At 37 weeks of gestation, she delivered a healthy male infant weighing 2800 grams via caesarean section. During this subsequent caesarean section, the lower uterine segment was observed to be of adequate thickness, and the placenta was implanted in the fundus, not in the lower uterine segment.

Conclusions

Hysteroscopy-guided laparoscopic Caesarean Scar Defect (CSD) repair is a feasible and safe procedure. This case demonstrates that such surgical intervention can lead to the resolution of

symptoms like postmenstrual spotting and contribute to successful subsequent pregnancy outcomes, particularly in patients with a very thin residual myometrial thickness who desire future fertility.

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Surgical Technique of Laparoscopic Mesh-less Pectopexy for Uterine Prolapse

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Background

To describe the surgical steps of laparoscopic pectopexy without the use of a mesh.

Methods

Narrated surgical video. Local institutional review approval not required, patient consent was obtained.

47-year-old, multiparous patient was admitted to hospital with abnormal uterine bleeding and a 6-centimeter uterine fibroid. She also had pelvic organ prolapse and her POPQ score was as follows; Aa: -1, Ba: +1, C: +2, Ap: -1, Bp: -2, D: -1.

Results

After routine laparoscopic hysterectomy and bilateral salpingo-oophorectomy, meshless pectopexy was performed to correct apical prolapse. Meshless pectopexy can be performed safely by following those steps: 1. Peritoneal incision from the right end of the vaginal cuff to the level of the right pectineal ligament. 2. Identification of the pectineal ligament lateral to the medial umbilical ligament on the right side. 3. Repetition of steps 1 and 2 on the opposite side. 4. Passing of a non-absorbable monofilament polypropylene suture (Prolene 0, Ethicon Inc; Johnson & Johnson, Somerville, NJ, USA) through the pectineal ligament and knotting on one side. 5. Passing the suture through the vaginal cuff two or three times and tying with sufficient tension. 6. Repetition of steps 4 and 5 on the opposite side. 7. Closure of the parietal peritoneum with absorbable, knotless suture (V-locTM, Covidien, Inc, Mansfield, Massachusetts).

Conclusions

Laparoscopic pectopexy was developed as an alternative method to sacrocolpopexy. In the original method, the cervix uteri or vaginal cuff is suspended to the bilateral pectineal ligament using a mesh. The use of mesh poses risks such as that of erosion. Some modifications of the original technique using mersilene tape or polyester sutures instead of a mesh to prevent erosion have been described. However, data are limited. The meshless modification of laparoscopic pectopexy with prolene sutures is a safe and reproducible method, eliminating the risk of mesh erosion, especially in cases with simultaneous hysterectomy.

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Isolated Fallopian Tube Torsion: Diagnostic Challenge and Minimally Invasive Treatment

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Background

Isolated fallopian tube torsion (IFTT) is a rare clinical entity characterized by the twisting of the fallopian tube in the absence of concurrent ovarian involvement. It represents an uncommon cause of acute gynaecological abdomen, with an estimated incidence of approximately 1 in 1.5 million women. IFTT predominantly affects women of reproductive age. Due to its nonspecific clinical presentation, diagnosis is often delayed, posing a challenge in timely management.

Methods

This presentation involves human subjects and was approved by an institutional ethics committee. A 23-year-old nulliparous, married woman presented to our outpatient clinic with a 5-day history of persistent pelvic pain. Her medical history was unremarkable. On physical examination, tenderness and rebound were noted in the left lower quadrant, while gynaecological examination revealed no abnormalities. Transvaginal ultrasound showed a normal uterus and right adnexa. However, a 34 × 35 mm cystic mass was identified in the left adnexa, along with an approximately 4 cm cystic lesion extending from the pouch of Douglas toward the right adnexa. Laboratory tests showed normal haemoglobin and white blood cell counts, with a mildly elevated C-reactive protein (CRP). Serum tumour markers, including AFP, CEA, CA-125, CA 19-9, and CA 15-3, were within normal limits. Pelvic Magnetic Resonance Imaging (MRI) with contrast revealed a dilated and torsed left fallopian tube, along with a 35 × 36 mm paratubal or fimbrial cyst containing hemorrhagic components. These findings were consistent with left isolated tubal torsion accompanied by tubal necrosis and a paratubal cyst. The patient underwent laparoscopic surgery. Intraoperatively, the uterus, left ovary, and right adnexa appeared normal. A cystic mass of approximately 4 cm was observed in the left paratubal region. The left fallopian tube was noted to be torsed with two twists at the ampullary level and appeared necrotic. Haemorrhagic free fluid was detected in the pouch of Douglas. A left salpingectomy was performed, and the procedure was completed without complications.

Results

The total operative time was approximately 20 minutes. Histopathological examination confirmed findings consistent with necrotic tubal torsion. The postoperative course was uneventful, and the patient was discharged on the first postoperative day.

Conclusions

In this case, the diagnosis was established through MRI, and laparoscopic exploration confirmed IFTT, enabling the successful removal of the necrotic fallopian tube. Importantly, the ipsilateral ovary was preserved. This case highlights the importance of clinical awareness of IFTT and emphasizes the role of timely surgical intervention in preserving fertility.

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Excision of the deep endometriotic nodule adjacent to the ureter and cervix using indocyanine-green

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Background

Endometriotic lesions may lead to ureteral obstruction, resulting in hydroureteronephrosis and potential compromise or loss of renal-ureteral function rarely. This condition often presents with nonspecific symptoms and is regarded as a silent disease, contributing to diagnostic challenges and delays in preoperative identification, while also necessitating advanced surgical techniques for effective management. The intraoperative use of indocyanine-green for assessing ureteral vascularity significantly reduces the risk of ureteral complications during endometriosis surgery. The aim is to demonstrate ureteral dissection using indocyanine-green in cases of deep infiltrative endometriosis localized to the cervix and uterus vicinity.

Methods

A reproductive-age female, has no further desire for fertility, was diagnosed with left-sided hydroureteronephrosis. The patient presented with left-sided predominant dysmenorrhea and dyspareunia, raising clinical suspicion for deep infiltrating endometriosis. Preoperative imaging and clinical evaluation identified a 2 to 3 cm endometriotic nodule adjacent to the cervix.

Results

At the start of the surgery, the peritoneum is opened and the relevant anatomical structures are visualized. Performing pelvic dissections step by step and carefully is extremely important for surgical safety. The use of indocyanine-green is important for assessing vascularization in cases where ureter dissection is performed.

Conclusions

In conclusion, to diagnose deep endometriosis, it is first necessary to consider even the rare cases of endometriosis. After making the diagnosis, both up-to-date approaches should be known and dissection should be performed patiently and carefully with accurate anatomical knowledge in order to manage the disease properly and apply safe surgical techniques.

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When Pain Persists: Coexistence of Pelvic Congestion Syndrome and Deep Endometriosis

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Background

Chronic pelvic pain in reproductive-age women may stem from multiple coexisting pathologies such as endometriosis and pelvic congestion syndrome (PCS). Accurate diagnosis and individualized management are crucial in patients with persistent symptoms despite intervention.

Methods

A 40-year-old woman with a history of two caesarean sections and laparoscopic cholecystectomy presented with one year of chronic pelvic pain. She had a history of stenting of the left ovarian vein due to PCS and underwent left gonadal vein embolization, without relief. Gynaecological symptoms included severe dysmenorrhea (VAS 9–10), dyspareunia (VAS 7–8), dyschezia (VAS 7–8), and urinary urgency with pain. She reported bilateral pelvic pain, right leg pain radiating anteriorly below the knee, and right sacrouterine ligament tenderness on examination. Menstrual cycles were regular but prolonged with pre- and postmenstrual spotting. Past medical history included mitral valve calcification, managed medically. There was no known allergy.

Results

Pelvic examination revealed a nodular, tender retrocervical area. Imaging showed bilateral ovarian endometriomas (<2 cm), a normal uterus, and a positive sliding sign. Intraoperative findings confirmed right sacrouterine ligament involvement. She underwent left salpingo-oophorectomy. Pathology revealed left ovarian endometriosis and chronic salpingitis. Despite previous ovarian vein intervention, retrocervical nodularity and pain persisted, consistent with deep infiltrating endometriosis.

Conclusions

This case highlights the complexity of managing chronic pelvic pain with coexisting endometriosis and PCS. Retroperitoneal fibrosis and retrocervical involvement may persist despite vascular interventions. Multidisciplinary assessment and surgical excision remain vital for symptom control in refractory cases. Careful evaluation for deep endometriosis should be considered in patients with persistent pain following treatment for PCS.

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Laparoscopic excision of deep endometriotic nodule at the uterosacral ligament and coexisting ovarian endometrioma

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Background

We aim to present the laparoscopic management and postoperative outcome of a patient with deep infiltrating endometriosis affecting the bilateral uterosacral ligaments and a concomitant large ovarian endometrioma.

Methods

A 41-year-old female with chronic left groin pain underwent comprehensive preoperative assessment. Vaginal examination identified a 1.5 cm posterior vaginal wall nodule, and transvaginal sonography revealed a 10 cm left ovarian endometrioma. A laparoscopic approach was performed. Following pelvic inspection and adhesiolysis, the ovary was suspended to the pelvic sidewall using a T-Lift device to optimize visualization. The endometrioma was aspirated and its cleavage plane identified. Bimanual opposite traction was applied to strip the cyst wall from the ovarian cortex. Bilateral uterosacral ligament nodules were dissected from surrounding tissue and excised using bipolar energy and the Thunderbeat device. The ureters were identified and preserved throughout the dissection. The ovarian cortex was sutured with a 2/0 V-Loc suture, preserving ovarian reserve.

Results

Extensive pelvic adhesions and bilateral deep infiltrating endometriotic nodules were identified. Due to the close proximity of the ureters to the nodules, meticulous dissection was required. The endometrioma was completely excised with preservation of healthy ovarian tissue. Postoperative follow-up demonstrated complete resolution of preoperative pain. No complications occurred.

Conclusions

Laparoscopic excision of bilateral uterosacral ligament nodules and a large ovarian endometrioma was safely performed with preservation of ovarian tissue. Postoperative recovery was uneventful, and the patient experienced complete resolution of pain. Precise lesion localization, supported by intraoperative vaginal examination, is essential for optimal surgical outcomes.

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LAPAROSCOPIC MANAGEMENT OF STAGE IV ENDOMETRIOSIS WITH INTESTINAL INVOLVEMENT A MULTIDISCIPLINARY APPROACH

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Background

Endometriosis is an oestrogen-dependent disorder affecting young women, characterized by symptoms such as chronic pelvic pain, dysmenorrhea, dyspareunia, and infertility. It occurs in 6–10% of all women and this proportion rises to 35-50% among those presenting with pelvic pain and infertility or both (1).

Although there are many classifications, it can be roughly divided into 3 groups: ovarian endometrioma, peritoneal superficial endometriosis and deep infiltrative endometriosis (DIE). DIE with bowel involvement is a condition that poses significant challenges for both the patient and the surgeon.

While medical treatments can minimize lesions and alleviate symptoms, they do not offer definitive solutions, and surgical intervention is often necessary (2). The surgical approaches include shaving, discoid resection, and segmental bowel resection, with the choice depending on lesion size and location (3).

Methods

A 29-year-old female with a history of rectovaginal endometriosis presented with primary infertility and groin pain. She had previously undergone the placement of a double stent due to hydronephrosis and surgical removal of an ovarian cyst. Despite medical treatment, her symptoms persisted, leading to the decision for laparoscopic surgery. Intraoperatively, endometriotic implants were found in the Douglas space. The ureters were meticulously dissected, and endometriotic foci were excised. Following this, a general surgery team joined the procedure to remove endometriosis from the rectovaginal region, where a full-thickness rectal perforation was noted, necessitating a low anterior resection. Additionally, an appendectomy was performed due to observed appendiceal involvement. The surgical procedure concluded with the placement of a drain in the Douglas space.

Results

Surgical treatment of intestinal endometriosis is difficult. Shaving, disc resection and segmental bowel resection are the surgical treatment steps according to the morbidity of the procedure.

Conclusions

The surgical treatment of intestinal endometriosis should be carried out by a multidisciplinary team of experienced surgical practitioners.

References:

1. Giudice, L. C., & Kao, L. C. (2004). Endometriosis. *Lancet* (London, England), 364(9447), 1789–1799.

2. Alonso, A., Gunther, K., Maheux-Lacroix, S., & Abbott, J. (2024). Medical management of endometriosis. *Current opinion in obstetrics & gynecology*, 36(5), 353–361.
3. Donnez, O., & Roman, H. (2017). Choosing the right surgical technique for deep endometriosis: shaving, disc excision, or bowel resection?. *Fertility and sterility*, 108(6), 931-942.

<https://player.vimeo.com/video/1085693960?autoplay=1>

<https://esge.covr.be/cmdocumentmanagement/conferencemanager/documents/api/getdocument/14899/cmabstsms/0000216210/26b2100b817c9384bc1977bc78aaf3f3d6efb341317882b06d74497b5d6ee8c6>

Laparoscopic Pectopexy: A Uterus-Sparing Alternative for Apical Prolapse Repair

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Background

Laparoscopic pectopexy is an emerging, uterus-sparing alternative to sacrocolpopexy for the correction of apical pelvic organ prolapse. By suspending the cervix or vaginal vault to the iliopectineal (Cooper's) ligaments, it offers a safe and anatomically favourable approach, especially in patients where traditional sacral suspension may be challenging. This video demonstrates the step-by-step technique of laparoscopic pectopexy.

Methods

A 58-year-old multiparous woman presented with symptomatic stage III apical prolapse. After counselling, the patient opted for uterus-preserving prolapse repair. Laparoscopic pectopexy was performed under general anaesthesia. Using interrupted sutures and a Tucker device, a non-absorbable synthetic mesh was used to suspend the anterior cervix bilaterally to the iliopectineal ligaments. The mesh was peritonealised, and care was taken to avoid injury to the bladder, vessels, and nerves.

Results

The total operative time was 60 minutes with minimal blood loss. There were no intraoperative or postoperative complications. The video illustrates the exposure of the iliopectineal ligament, safe dissection along the round ligament, mesh fixation technique, and final peritoneal closure. At 6-week follow-up, the patient reported significant symptom relief with no evidence of recurrence or mesh-related issues.

Conclusions

Laparoscopic pectopexy is a viable and safe option for apical prolapse repair, particularly in patients with contraindications to sacrocolpopexy or who desire uterine preservation. This video provides a clear educational guide to the anatomic landmarks, mesh placement, and technical nuances of this procedure.

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cornual ectopic pregnancy following unilateral salpingo-oophorectomy: a rare case and surgical approach

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Background

cornual ectopic pregnancy is a rare and potentially life-threatening form of ectopic gestation, defined by implantation of the embryo within the intramural portion of the fallopian tube located in the upper-lateral uterine horn. although it accounts for only 2–4% of all ectopic pregnancies, it is associated with disproportionately high maternal morbidity and mortality due to the risk of late rupture, massive haemorrhage, and hypovolemic shock. Risk factors include prior tubal surgery or damage, pelvic inflammatory disease, uterine anomalies, and assisted reproductive techniques.

Methods

we present the case of a 26-years-old nulliparous woman with a history of right salpingo-oophorectomy(SO) performed nine years ago for a sertoli-leydig cell tumour. her serum b-hcg level was 651 iu/l at 30 days post-last menstrual period. six days later, she reported groin pain and β -hCG had risen to 3984 IU/L. transvaginal ultrasound showed no intrauterine gestational sac, a 12.6 mm endometrial thickness, and a 7.5 mm gestational sac with a yolk sac near the right cornu. no foetal pole was observed. despite two doses of systemic methotrexate (84 mg each), b-hcg levels continued to rise 9300 iu/l and a 2.1 mm fetal pole appeared. laparoscopic surgery was decided. the right adnexa were absent; ectopic gestational tissue was confirmed in the right cornu. a vicryl suture was placed around the lesion, followed by local vasopressin injection to minimise bleeding. the ectopic tissue was excised, and the uterine defect was closed with barbed sutures. haemostasis was achieved, endometrial curettage was performed.

Results

postoperative recovery was stable with no complications. patients b-hcg levels decreased to a non significant level on post operative follow up.

Conclusions

in cases of unilateral SO, the occurrence of ipsilateral ectopic pregnancy is very rare. theories such as transperitoneal migration of sperm or zygote and microscopic luminal continuity of the tubal stump have been proposed to explain such occurrences.

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LAPAROSCOPIC MANAGEMENT OF DEEP INFILTRATING BLADDER ENDOMETRIOSIS: A CASE REPORT

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Background

Endometriosis is a benign, oestrogen-dependent, chronic disorder affecting approximately %6-10 of women. It is characterized by endometrial tissue growth outside the uterus (1). Urinary tract endometriosis accounts for about %1 of all endometriosis cases, with bladder involvement observed in %80 of these instances. Symptoms often include dysuria and other urinary complaints (2).

Methods

We present the case of a 46 years old G0P0 woman with known deep infiltrating endometriosis affecting the bladder and grade 3-4 hydronephrosis in her left kidney, she has a double J stent in her left ureter, no history of other diseases or surgeries, her symptoms persisted despite medical treatment. Given her condition, we opted for laparoscopic excision of the endometriosis. During the operation, cystoscopy revealed a 3 cm endometriotic nodule protruding into the bladder. The surgical procedure included total laparoscopic hysterectomy, bilateral salpingo-oophorectomy, adhesiolysis, and partial bladder resection.

Results

Urinary tract endometriosis, particularly involving the bladder, is a rare form of deep infiltrating endometriosis. While medical therapy can alleviate some symptoms, it often does not provide a definitive solution; surgical intervention is frequently required. The surgical approach may involve segmental resection of the urinary tract, with radical procedures such as urostomy being necessary in rare cases(3).

Conclusions

Deep infiltrating endometriosis is a challenging disease of reproductive aged women. Treatment requires experienced surgeons and multidisciplinary approach. The first aim of therapy should be to enhance the patient's quality of life.

References:

1. Mert, Ş. A., Dilbaz, B., Ergani, S. Y., Kınay, T., Öcal, A., & Tekin, Ö. M. (2024). A Rare Case of the Bladder Endometriosis and Overview of the Literature. *Medical Research Reports*, 7(3), 172-176.
2. Wambugu, J., & Achila, B. (2024). Bladder endometriosis – diagnostic and management challenges: A case report. *Journal of Obstetrics and Gynaecology of Eastern and Central Africa*, 36(1).
3. Carmen Maccagnano, Federico Pellucchi, Lorenzo Rocchini, Massimo Ghezzi, Vincenzo Scattoni, Francesco Montorsi, Patrizio Rigatti, Renzo Colombo; Diagnosis and Treatment of Bladder Endometriosis: State of the Art. *Urol Int* 1 October 2012; 89 (3): 249–258.

<https://player.vimeo.com/video/1085719711?autoplay=1>
<https://esge.covr.be/cmdocumentmanagement/conferencemanager/documents/api/getdocument/14893/cmabstsms/0000216210/25d8a1b9ef815f3f6e2451941a9d926ec113028a8901e6f8907a8d35c5a6a0db>

Robotic-Assisted Excision of Deep Endometriosis with ICG Navigation: Enhancing Safety in Complex Pelvic Surgery

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Background

Deep infiltrating endometriosis (DIE) is a complex and debilitating condition, particularly in young women desiring future pregnancies.

Methods

We present the case of a 34-year-old nulligravida woman with a history of chronic pelvic pain and infertility, diagnosed with deep infiltrating endometriosis (DIE) classified as r-ASRM Stage IV (score 46), Enzian classification (s)P3, T0+/0+, A3, B3/3, C3, FA, FB, F(inguinal left), and EFI score of 8.

Imaging revealed focal anterior adenomyosis, a 5 cm endometriotic nodule in the torus extending into the right uterosacral ligament and abutting the upper rectum. With a suspicion of vesicouterine involvement .

Multidisciplinary evaluation recommended surgical management given persistent symptoms despite 3 months of progesterone therapy, which reduced pain but did not eliminate it. The patient elected for surgery and fertility preservation then medically assisted reproduction (MAR) .

Results

Intraoperative findings confirmed extensive DIE with bowel adhesions and nodules in the vesicouterine fold, left inguinal canal, torus, right uterosacral ligament, and upper rectum.

Ureters ICG mapping facilitated the ureterolysis. A rectal shaving, resection of rectal and inguinal nodules, and adhesiolysis was performed. Haemostasis was verified. The procedure was completed without perioperative complications.

The postoperative course was uneventful, with the patient discharged on day 3. At three months follow-up, she reported a marked reduction in pelvic pain and improvement in quality of life. She has since initiated a MAR protocol in pursuit of pregnancy.

Conclusions

This case highlights the complexity of managing endometriosis in the context of infertility and severe pain. A tailored, multidisciplinary approach involving gynaecologic surgery, pain management, and reproductive medicine is essential.

This video demonstrates advanced laparoscopic techniques for DIE excision, emphasizing organ preservation and fertility optimization

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A mesh-free modified laparoscopic sacrohysteropexy technique: ozerkan modification

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Background

To demonstrate a mesh-free laparoscopic sacrohysteropexy technique as an alternative to standard mesh-based approaches in the surgical management of apical pelvic organ prolapse, aiming to reduce mesh-related complications.

Methods

We present a 43-year-old female patient with no significant comorbidities and a history of three term vaginal deliveries. She presented with a perineal bulge, without urinary incontinence. Pelvic examination revealed grade 2 uterine prolapse and grade 2 rectocele, with no evidence of cystocele. A modified laparoscopic sacrohysteropexy procedure was performed using Mersilene tape instead of synthetic mesh. The posterior peritoneum from the promontory to the cervix was dissected. Anterior dissection of the bladder was also completed. Mersilene tape was passed medial to both uterine arteries and placed around the cervix at the isthmic level. The tape was fixed posteriorly with several knots and anchored to the promontory through the periosteum. Prolene sutures were used to secure the fixation, and the peritoneum was closed with 2-0 Vicryl. The tape was completely embedded in the retroperitoneal space.

Results

The surgery was completed successfully without intraoperative complications. Uterine support was effectively restored. No mesh was used, eliminating associated risks. Postoperative recovery was uneventful, and the patient reported resolution of bulge symptoms with preservation of uterine integrity.

Conclusions

This modified mesh-free laparoscopic sacrohysteropexy offers a safe and effective alternative to conventional mesh-based techniques in treating apical pelvic organ prolapse. It minimizes the risk of mesh-related complications while maintaining anatomical and functional outcomes.

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"One for All": Classic resectoscope for every endometrial pathology

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Background

Hysteroscopy is the gold standard technique for the evaluation and treatment of intrauterine pathology related to infertility, abnormal bleeding, and recurrent miscarriages. To review the role and prevalence of the classic resectoscope in the management of endometrial pathologies, highlighting its continued relevance and effectiveness compared to newer hysteroscopic instruments.

Methods

A comprehensive review of the literature was conducted to assess the clinical outcomes, procedural efficacy of the resectoscope and the spectrum of endometrial pathology that can be treated with resectoscope in comparison to other hysteroscopic instruments, including bipolar electrodes, Bettocchi operating hysteroscope, laser systems, and Bigatti shaver. In this video we demonstrated the wide use of resectoscope in treatment of different uterine pathologies. Informed consent to present and publish was obtained from all patients involved in the study.

Results

The resectoscope remains a cornerstone in hysteroscopic procedures, particularly for fibroid, polyp resection and endometrial hyperplasia. Despite advancements in hysteroscopic technology and instruments, the resectoscope continues to demonstrate high efficacy in almost every hysteroscopic procedure compared to newer instruments. Its mechanical resection capabilities offer precise excision of pathology, achieving up to 92% efficacy in fibroid removal and 99% in polypectomy. Even the removal of the uterine septa can be carried out with the resectoscope. In this video we presented high efficacy of only one hysteroscopic instrument (resectoscope) in almost every endometrial pathology. Moreover, the cost-effectiveness and wide availability of the resectoscope make it a preferred choice in resource-limited settings. In hospitals with a limited budget and the ability to acquire only one hysteroscopic instrument, the resectoscope is a viable solution compared to other instruments. Resectoscope can be used in almost every endometrial pathology. Finally, its familiarity among surgeons and especially among residents maintain its prevalent use in clinical practice.

Conclusions

The classic resectoscope remains a valuable and effective instrument for managing endometrial pathologies despite the advent of newer hysteroscopic devices. Its established efficacy in fibroid and

polyp resection underscores its continued relevance, particularly in settings where cost and surgeon experience are pivotal.

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Haemorrhage During Hysteroscopic Myomectomy of FIGO Type 2 Fibroid

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Background

Hysteroscopic myomectomy is a minimally invasive procedure used to remove submucosal fibroids, including FIGO type 2 fibroids, while preserving uterine integrity. However, haemorrhage remains a significant intraoperative complication that can impact surgical outcomes. This case aims to outline effective strategies to prevent and manage haemorrhage during hysteroscopic myomectomy of FIGO type 2 fibroids, with a focus on fertility preservation

Methods

A 42-year-old women with menorrhagia presented to our department. Preoperative evaluation includes transvaginal ultrasound, which revealed the presence of multiple submucosal fibroid FIGO type 2 with the biggest one (3 cm) located within the posterior wall. MRI was performed to assess fibroids' size and their precise location. Intraoperatively, the use of bipolar electrosurgical systems (resectoscope) facilitates haemostasis while minimizing thermal damage to surrounding tissue. In this video we demonstrated severe intraoperative bleeding during hysteroscopic myomectomy (FIGO type 2, 3.5 cm) of the posterior uterine wall, which was successfully managed using carefully resectoscope. Mechanical techniques such as insertion of Foley catheter in the endometrial cavity immediately after the removal of hysteroscopic instruments was also employed to treat the severe bleeding. Informed consent to present and publish was obtained from the patient involved in the study.

Results

Effective use of bipolar electrosurgical systems without losing your composure and carefully persisting at the point of bleeding significantly reduces intraoperative blood loss. Haemorrhage control methods contribute to decreased operative time and minimize the risk of uterine perforation. Optimal surgical techniques enhance patient recovery and fertility outcomes post-procedure.

Conclusions

Haemorrhage management during hysteroscopic myomectomy of FIGO type 2 fibroids is essential to ensure successful outcomes and preserve reproductive function. A comprehensive approach that includes preoperative planning, meticulous surgical techniques, and intraoperative haemostasis is crucial for minimizing complications and optimizing patient outcomes.

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Fibroid Focus: 6 Steps for effective Laparoscopic Myomectomy

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Background

Laparoscopic myomectomy is a minimally invasive surgical technique used for the removal of uterine fibroids (myomas) while preserving the uterus. It is an effective alternative to open myomectomy, with many benefits. However, challenges such as intraoperative bleeding and uterine wall integrity necessitate a structured, stepwise approach to optimize surgical outcomes. This video outlines a six-step methodology for performing laparoscopic myomectomy, focusing on techniques to minimize blood loss, ensure efficient myoma enucleation, and restore myometrial integrity.

Methods

The procedure follows a six-step approach:

1-Blood Loss Reduction:

(a)Preoperative selective uterine artery embolisation. (b)Uterine artery cauterization at its origin.

(c)Vasopressin infiltration into the myometrium.

2-A linear or elliptical incision over the myoma to expose the fibroid. The choice of incision is guided by the planned direction of suturing to facilitate optimal uterine closure.

3-A myoma screw and graspers are used to apply traction and counter-traction, aiding in fibroid mobilization and facilitating its removal with minimal tissue damage.

4-Myoma Enucleation: The myoma is carefully dissected from its pseudocapsule, ensuring complete removal while minimizing trauma to the surrounding myometrium.

5-Suturing of the Myometrial defect is performed in layers to achieve haemostasis and restore uterine integrity. Barbed or interrupted sutures are used depending on the location and size of the defect.

6-The extracted fibroid is retrieved either by morcellation in a containment bag or extraction through minilaparotomy, depending on the fibroid size and surgeon preference.

Results

see Video for precision and effectiveness.

Conclusions

A systematic, six-step approach to laparoscopic myomectomy enhances surgical precision, minimizes intraoperative blood loss, preserves uterine function, and accelerates postoperative recovery.

Implementing these techniques ensures optimal outcomes while reducing complications.
Laparoscopic myomectomy remains a safe and effective option for fibroid management.

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The impact of the nature of subseptate uterus on the technique of hysteroscopic septoplasty

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Background

Septate uterus is one of the most common Müllerian anomalies, and it could be associated with poor reproductive outcomes. The size, shape, and composition of a subseptate uterus can vary regarding width, length, and vascularity. Our project aims to describe the different techniques of septoplasty depending on the nature of the septum.

Methods

Two patients undergoing hysteroscopic septoplasty with differing pathology are shown. Although various tools exist to perform septoplasty, we highlight scissors and the monopolar resectoscope loop.

Results

Patient 1 underwent septoplasty. Hysteroscopic scissors were initially used, but bleeding was noted due to the vascularity of the septum. The decision was made to switch to a monopolar resectoscope due to availability. The energy provided by the resectoscope was able to quickly decrease bleeding. Having an energy device readily available was pertinent to complete the procedure. Patient 2 underwent septoplasty. Hysteroscopic scissors were used, and minimal bleeding was noted due to the fibrous septum nature. When septoplasty was completed and the myometrial layer was seen, a bipolar device was used to coagulate bleeders at the myometrial layer. This septum and technique were different than the first patient and highlight the variability in the pathology of septi and the different approaches that can be used depending on the septum's nature.

Conclusions

In conclusion, these two patients highlight the importance of being able to identify the variations in uterine septi and the importance of versatility. It is important to have proper instruments available that the surgeon is comfortable with. Scissors are preferred, but if a vascular septum is identified, having an energy device is necessary. Bipolar is preferred; however, in our case, due to availability, monopolar was used. Additionally, these two cases highlight that imaging tests are useful in helping aid decision making, but diagnostic hysteroscopy is the gold standard for correct diagnosis.

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Hysteroscopic resection of type 3 fibroids

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Background

This video presents a step-by-step surgical technique for the hysteroscopic resection of FIGO type 3 fibroids, aiming to improve reproductive outcomes in infertile women. Although these fibroids do not distort the endometrial cavity, evidence suggests a negative impact on IVF success rates. A recent meta-analysis (Favilli et al., 2023) showed significantly lower implantation, clinical pregnancy, and live birth rates in patients with untreated type 3 fibroids. Hysteroscopic resection is a minimally invasive alternative that has shown improved clinical outcomes compared to non-surgical management (Han et al., 2022).

Methods

We present a step-by-step technique for hysteroscopic resection of type 3 fibroids: (1) Preoperative preparation with desogestrel or radiofrequency to reduce vascularization; (2) Fibroid localization via ultrasound; (3) Superficial incision to confirm correct targeting; (4) Lateral incision to identify the pseudocapsule for better dissection; (5) Size reduction starting from the periphery to improve the continent-to-content ratio; (6) Coagulation of central vessels to minimize bleeding.

Results

To date, we have performed this technique in 12 patients with FIGO type 3 fibroids. A total of 20 procedures were carried out: 58.3% required one intervention, 33.3% two, and 8.3% three. Of all procedures, 72.2% were performed in an office setting. Postoperative pain was low, with a mean VAS score of 2.9. All patients were discharged the same day, and no major complications were reported. Patient tolerance was excellent.

Conclusions

These preliminary results suggest hysteroscopic resection of type 3 fibroids is a safe, effective, and well-tolerated option in selected patients. Its minimally invasive nature allows same-day discharge, rapid recovery, and high patient satisfaction. Hysteroscopy may be a valuable alternative to laparoscopic or abdominal myomectomy, especially for women seeking fertility preservation. Further prospective studies are needed to confirm long-term reproductive outcomes and define standardized surgical guidelines.

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Laparoscopic Adhesiolysis with Segmental Bowel Resection: A Case of Deep Infiltrating Endometriosis

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Background

Deep infiltrating endometriosis is a severe form of endometriosis that extends beyond the peritoneum and can involve multiple pelvic structures, including the bowel, urinary tract, and uterosacral ligaments. When the rectosigmoid colon is affected, patients may present with chronic pelvic pain, dyschezia, and infertility. Surgical treatment is often complex due to dense adhesions and the need for bowel resection. Minimally invasive approaches, when feasible, offer advantages in recovery and visualization, but require a skilled multidisciplinary team.

we aim in this article, to present the surgical approach, technique, and outcomes of laparoscopic management of deep infiltrating endometriosis involving the rectosigmoid colon, with associated extensive pelvic adhesions, through adhesiolysis and segmental bowel resection.

Methods

A 36-year-old female with a history of chronic pelvic pain and infertility underwent a combined diagnostic and operative procedure including hysteroscopy using a mini-resectoscope, cystoscopy with indocyanine green dye, and advanced laparoscopic adhesiolysis. Surgical steps included bilateral tubal clipping using energy sealing devices, excision of deep infiltrating endometriosis lesions, and segmental resection of the rectosigmoid colon. Intraoperative findings revealed dense adhesions of the sigmoid colon to the left pelvic wall causing rotation of the rectosigmoid, a rectal nodule located 11 centimetres from the anal verge, and bilateral adnexal encapsulation with involvement of the uterosacral ligaments and torus of the uterus. The affected bowel segment measuring approximately 9 centimetres was resected using a laparoscopic gastrointestinal anastomosis stapler. The segment was exteriorized through a Pfannenstiel incision and re-anastomosed intracorporeally using a circular stapler.

Results

The procedure was completed laparoscopically with a total estimated blood loss of 200 millilitres. Complete excision of all visible endometriotic lesions was achieved, including the segmental resection of the rectosigmoid colon. The bowel anastomosis was intact with no leakage confirmed by the intraoperative air insufflation test. Both fallopian tubes were released but clipped due to extensive damage from adhesions and endometriosis. Hemostasis was thoroughly secured and the patient experienced an uneventful postoperative recovery.

Conclusions

Laparoscopic management of deep infiltrating endometriosis involving the rectosigmoid colon is feasible and safe when performed by an experienced surgical team. Segmental bowel resection can be successfully executed with effective haemostasis and anatomical restoration using minimally invasive techniques. This case highlights the importance of a comprehensive surgical strategy and

demonstrates the potential for fertility-preserving treatment despite the presence of extensive disease.

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Surgical Treatment of Utero-Intestinal Fistula and Its Impact on Fertility

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Background

This study aims to highlight the importance of timely diagnosis and surgical treatment of utero-intestinal fistulas, a rare condition that can severely impair fertility, especially when caused by intrauterine device (IUD) complications.

Methods

A clinical case was analysed involving a reproductive-aged woman who presented with an IUD found in the rectum and later experienced pregnancy loss. A utero-intestinal fistula was diagnosed via hysteroscopy, and the patient underwent laparoscopic excision of the fistula under hysteroscopic guidance.

Results

Following minimally invasive surgical treatment, the patient was able to conceive naturally. The pregnancy was successfully carried to term and delivered via planned caesarean section, confirming the restoration of reproductive function.

Conclusions

Minimally invasive surgical management of utero-intestinal fistulas, guided by accurate diagnosis, can effectively restore fertility. A multidisciplinary and individualized approach is essential for optimal reproductive outcomes in such rare cases.

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Culdotomy for tissue extraction after laparoscopic myomectomy: A case series reporting on an underutilized minimally invasive surgical technique.

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Background

Laparoscopic myomectomy has significantly transformed the treatment of uterine fibroids in women with fertility aspirations. This minimally invasive technique offers lower surgical trauma, infection, bleeding & adhesion rates compared to the traditional mode of open surgery. There are multiple tissue extraction methods such as power morcellation, manual cold knife coring, mini-laparotomy (Pfannenstiel) or transvaginal extraction with posterior culdotomy.

Methods

We present a case series of 5 patients and demonstrate a step-by-step video technique regarding a 37-year-old, Para 0 presenting with abnormal uterine bleeding on a background of an anterior intramural fibroid abutting the endometrial cavity (FIGO Type 3), 4.2x4 cm on departmental transvaginal ultrasound scan. The patient was counselled for diagnostic hysteroscopy and laparoscopic myomectomy at our institution.

Results

Laparoscopy myomectomy was performed following standard surgical steps of 10mls of Vasopressin (Pitressin) injection (diluted 1:200 normal saline), monopolar hook and graspers for fibroid enucleation, with minimal use of bipolar diathermy for haemostasis and layered uterine closure with intracorporeal suturing (myometrium with Vicryl 1 & serosa with Philbloc 2.0). Culdotomy was performed for fibroid extraction using a vaginally inserted McCartney tube. Uterosacral ligaments (USLs) and torus uterinus were identified, and a curvilinear culdotomy was performed just above the USLs. The fibroid was removed using an endobag and the vaginal vault was closed laparoscopically using a continuous suture Monocryl 1. Operative time was 60min and estimated blood loss was under 100 mls. The histology report confirmed a benign leiomyoma with no evidence of atypia or malignancy.

Conclusions

Culdotomy for transvaginal fibroid tissue extraction is an often-underutilised technique that significantly affects postoperative outcomes, including accelerating recovery speed and reducing complication rates.

Though this case series is limited by the small number of participants, it demonstrates good recovery from the procedure without reported adverse outcomes some as chronic pelvic pain or dyspareunia.

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Video in ePoster

Laparoscopic Ovarian Cystectomy: A Video-Based Comparison of Monopolar Hook, Bipolar and Scissor, and Hydrodissection Techniques, and different methods in removal of the cyst

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Background

Laparoscopic ovarian cystectomy is a widely used technique for the management of benign ovarian cysts, particularly in women of reproductive age where preserving ovarian function is a priority. The selection of surgical tools and dissection methods can significantly influence tissue preservation, intraoperative bleeding, and overall surgical efficiency.

Methods

This video case study features a laparoscopic cystectomy performed on a patient with a benign ovarian lesion. Four dissection techniques were demonstrated: monopolar hook, bipolar forceps, laparoscopic scissors, and hydrodissection. Each method was utilized on a distinct segment of the cyst to illustrate differences in tissue handling, visibility, and control of bleeding. Key procedural steps such as cyst incision, wall separation, and ovarian reconstruction were recorded for analysis and teaching purposes.

Results

The monopolar hook allowed for controlled dissection but required careful use near vascular structures due to the potential for thermal injury. Bipolar forceps were effective for haemostasis but caused noticeable thermal changes in adjacent tissue. Cold scissors provided clean cuts and preserved ovarian tissue well, though without intrinsic coagulation. Hydrodissection proved particularly useful in gently separating the cyst from the ovarian cortex, reducing mechanical traction and thermal damage. The entire procedure was completed without complications, with excellent preservation of ovarian architecture and minimal blood loss.

Conclusions

Different dissection techniques offer unique advantages during laparoscopic ovarian cystectomy. While no single method is universally superior, hydrodissection stands out as a valuable adjunct in cases where tissue conservation is essential. Adapting the surgical approach based on intraoperative findings can lead to better outcomes and enhanced safety in minimally invasive gynaecologic surgery.

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Recurrent endometriosis of the uterine wall with acute haemorrhage- A Rare Case Report

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Background

Endometriosis is a common gynaecological condition characterized by the presence of endometrial tissue outside the uterine cavity. However, recurrent endometriosis of the uterine wall with acute haemorrhage is a rare and potentially life-threatening presentation, particularly in young women. This case report aims to highlight the diagnostic challenges, surgical management, and fertility implications of recurrent endometriosis of the uterine wall with acute haemorrhage in a young female patient.

Methods

A 42-year-old patient presented at the Emergency Department with acute abdominal pain, dizziness and nausea. Following work-up revealed a cystic lesion of the right parametrium and signs of intrabdominal bleeding, so urgent laparoscopy was decided. Surgical intervention involved laparoscopic resection of the endometriotic lesions with careful hemostasis to preserve uterine integrity. Histopathological examination confirmed the diagnosis of endometriosis with extensive vascular involvement. Symptom recurrence and imaging techniques 2 months postoperatively indicated recurrent endometriosis of the right broad ligament. Re-operation for total hysterectomy and bilateral salpingo-oophorectomy was subsequently decided. Informed consent for publication has been obtained from the patient.

Results

Successful surgical management initially involved complete excision of the endometriotic lesions and control of haemorrhage using bipolar coagulation and layered suturing. Postoperative examination and imaging were suggestive of recurrent endometriosis. The patient opted for total hysterectomy, during which recurrent endometriosis of the right broad ligament was recognised. Indeed, the endometriotic lesion infiltrated the right uterine wall, which deemed the condition unresectable with a fertility-sparing operation. The patient recovered successfully, requiring only hormonal supplementation.

Conclusions

Recurrent endometriosis of the uterine wall with acute haemorrhage is a rare but serious condition that requires prompt diagnosis and surgical intervention. In this case, total hysterectomy and BSO was considered necessary due to the infiltrating and recurrent nature of the condition. Comprehensive preoperative assessment, meticulous surgical techniques, and vigilant postoperative monitoring are crucial for optimizing outcomes in affected women.

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Laparoscopic myomectomy in a patient with multiple Figo type 5 fibroids and a desire for fertility preservation.

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Background

Laparoscopic myomectomy is a minimally invasive surgical technique beneficial for patients who desire to preserve fertility. It involves the removal of uterine fibroids while maintaining the structural integrity of the uterus. This review aims to outline key strategies and techniques to optimize outcomes in laparoscopic myomectomy for fertility preservation and raise awareness regarding the cost-effectiveness of laparoscopic contained fibroid morcellation.

Methods

A 40-year-old patient with abnormal uterine bleeding, pelvic discomfort and infertility presented to our department. Subsequent imaging with ultrasound and MRI revealed multiple Figo type 5 fibroids, ranging from 4 to 9cm in diameter, located in the fundus, posterior and right uterine wall.

Laparoscopic myomectomy was decided. Vasopressin is administered within the fibroids in order to reduce intraoperative bleeding. The fibroid is dissected from its pseudocapsule using meticulous techniques to minimize tissue damage and prevent adhesions. Haemostasis is achieved with bipolar coagulation, and uterine defects are sutured in multiple layers using barbed sutures. Removal of fibroids was achieved with contained morcellation within a large endoscopic bag. Informed consent for publication has been obtained from the patient.

Results

Effective implementation of these techniques reduces intraoperative blood loss, minimizes tissue trauma, and preserves uterine integrity. The use of barbed sutures facilitates secure closure and decreases operative time. Optimized surgical methods contribute to improved fertility outcomes post-procedure. Morcellation for multiple, large fibroids proved time-consuming (approximately 60 minutes) and physically challenging for the surgeon. Alternative ways for fibroid removal include performing a mini-laparotomy, which significantly reduces operative time and cost, without accordingly decreasing patient satisfaction.

Conclusions

Laparoscopic myomectomy, when performed with attention to detail and strategic planning, can effectively treat fibroids while preserving fertility. Adherence to key techniques, such as minimizing tissue trauma and ensuring haemostasis, is crucial for optimizing reproductive outcomes.

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Pelvic recurrence of endometrial cancer treated by laparoscopic laterally extended resection (LEER): a clinical case with 3D-reconstruction and surgical technique

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Background

Despite early diagnoses and excellent survival rates, a non-negligible proportion of patients with endometrial cancer experience relapse. The management of patients with recurrence poses a clinical challenge due to the heterogeneity of recurrent disease, which is influenced by several factors, including the anatomical site of relapse, primary treatments, chemo- and/or radio-sensitivity, and the clinical characteristics of the patients. Literature supports survival benefits in patients with recurrent endometrial cancer undergoing secondary cytoreductive surgery with complete gross resection.

Methods

We present the case of an oligometastatic pelvic recurrence of low-risk endometrial cancer in a woman in her 60s. Preoperative MRI and PET-CT scans revealed three nodular lesions with increased uptake in the right pelvic region, along the right external iliac vessels, attached to the ipsilateral iliopsoas muscle, in the right obturator region, and between the internal and external obturator muscles. Given the oligometastatic recurrence, and after multidisciplinary discussion, the patient was advised to undergo secondary cytoreductive surgery. In this video, we showed a minimally invasive approach tailored to the patient's disease, aided by preoperative 3D reconstruction.

Results

We achieved a residual tumour of zero with favourable operation times, and no intraoperative or postoperative complications occurred. Final histology confirmed metastatic involvement of endometrial cancer. After a multidisciplinary board evaluation, the patient adjuvant chemotherapy was proposed.

Conclusions

The use of a minimally invasive approach may be feasible and safe for selected patients in oncological centres, favouring a faster postoperative recovery and an earlier access to adjuvant therapies. Furthermore, surgical removal of the recurrence allows for biological and molecular analysis of the malignant tissue, contributing to a deeper understanding of aggressive recurrences, particularly those that are less expected, such as in low-risk patient groups.

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Bladder Injury Repair During Total Laparoscopic Hysterectomy in Assistant Training in the Department of Obstetrics and Gynaecology

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Background

Minimally invasive surgery has become frequently used, especially in hysterectomy. In this case report, we present a case of bladder injury and repair in a patient undergoing TLH for endometrial intraepithelial neoplasia.

Methods

48 years old, G2, P2, with a history of 2 caesarean section operations, was admitted to our clinic due to menorrhagia and dysmenorrhea. On examination, the endometrium measured 12 mm and irregular, and endometrial biopsy was recommended. The biopsy result was reported as endometrial intraepithelial neoplasia. Total laparoscopic hysterectomy and bilateral salpingoopherectomy were planned.

The operation was performed under general anaesthesia in the lithotomy position with the help of a uterine manipulator.

The operation was started by placing three 5 mm instrument ports and one 10 mm camera port. Firstly, bilateral infundulopelvic and round ligaments were dissected with the help of ligasure, then anterior and posterior leaves of lig.latum were cut. Then anteriorly, the bladder, cervix and vagina were dissected from the anterior wall, bilateral a.uterinas were coagulated, then lig.sacruterina and lig.cardinale were cut, then the uterus was cut circularly with the help of harmonic at the level of the cervicovaginal junction and sent to pathology for frozen.

During bladder dissection, it was observed that there was approximately 2 cm bladder injury. The patient was then evaluated by intraoperatively to urology department and they suggested to suture the bladder mucosa, m.detrusor primary with 0 vicryl, serosa layer with 2.0 vicryl Lambert suture, then to control water tightness Retrograde filling bladder with normal saline with methylene blue which we have go thoroughly. Intraabdominal drain placed. Afterwards, vaginal cuff sutured with vlock suture. Frozen reported as no malignancy.

Results

The postoperative period went without complications. Intraabdominal drain was removed at the 3rd day. The patient was discharged

after 4 days with a urinary catheter and solifenacin succinate. The urinary catheter was removed on the 10th day after discharge.

On the 30th postoperative day, the patient was evaluated with USG and a total bladder volume of 470cc followed by 20 cc residual volume of urine was observed.

She stated that there was no urinary retention difficulty, no nocturia, no increased frequency of urination, and no urinary incontinence after urgency.

Conclusions

To prevent bladder injury, especially in patients with a history of previous surgery, sharp dissections should be preferred instead of blunt dissections, a lateral to medial approach should be adopted, making sure that the bladder is emptied, and if the bladder borders cannot be clearly distinguished, retrograde filling with normal saline reduces the risk of surgical injury. cephalad traction on a uterine manipulator help mobilize the bladder away from the uterine arteries.

Care should be taken when using electrocautery to avoid late complications (fistula)

During surgical repair, polyglactin or polyglecaprone absorbable sutures should be preferred to cause less bladder tissue reaction.

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Accessory Cavity of Uterine Mass (ACUM) , Rare But Possible Scenerio in Chronic Dysmenorrhea

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Background

Accessory cavity uterine mass (ACUM) is a rare Müllerian anomaly that can cause chronic pelvic pain, dysmenorrhea and dyspareunia. This accessory cavity has no connection to the endometrial layer of the uterus. It has its own functional endometrial layer and a myometrium-like smooth muscle cell layer surrounding it. This gives it a similar appearance to the uterine cavity. Imaging techniques such as USG and MRI help us to suspect the diagnosis. On USG, ACUM appears as unilocular myometrial cysts, usually with ground-glass content. Haemorrhagic content is also observed on MRI, with high signal intensity on both T2 and T1-weighted images.

Methods

A 24-year-old woman presented to the emergency room with severe pelvic pain. In the history, we learned that the patient's dysmenorrhea started with menarche. On ultrasound, we found a 4 cm mass compatible with haemorrhagic appearance independent from the uterine cavity in the fundus of the uterus. The patient's complete blood count was normal, crp was negative, and blood pregnancy test was negative, and tumour markers are negative. Contrast-enhanced MRI was planned for further examination. Hypointense on T1 sequence and hyperintense on T2 sequence were observed. L/S was planned for diagnostic purposes. On laparoscopy, the mass was found to be attached to the right anterior uterine wall just below the attachment of right round ligament. Bilateral fallopian tubes and ovaries were normal with no endometriotic deposits. A transverse incision was made over the anterior wall of the mass and 8-10 ml of chocolate-coloured fluid was drained. The uterine cavity was not entered into. There was no communication with the main uterine cavity. At surgery, the ACUM was not encapsulated but was possible to enucleate. The cyst wall was removed with the help of ligasure. The remaining myometrium tissue was sutured by v-loc.

Patient consent to present and publish was obtained.

Results

Ameliyat sonrası seyir sorunsuzdu ve hasta semptomatik olarak giderek iyileşti. 4 hafta sonra hasta, adet dönemindeki önceki ağrısına dair hiçbir iz olmadığını belirtti. Materyallerin histopatolojisi, bezler ve stroma ile çevrili, düzensiz düzenlenmiş düz kas hücreleri ile çevrili, fonksiyonel endometrium ile kaplı kaviteli bir kitle ortaya koydu.

Conclusions

In order to diagnose ACUM, there are a few criteria that we need to pay attention to. After seeing normal uterus, fallopian tubes and ovaries, we need to see an accessory cavity under the round

ligament. This cavity has a chocolate brown liquid content, and the pathologic findings should include glands and stroma of the endometrium. MRI is highly accurate in making the diagnosis.

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Laparoscopic prophylactic gonadectomy in a patient with 45, X/46, XY mixed gonadal dysgenesis

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Background

Mixed gonadal dysgenesis (MGD) is a rare disorder of sex development. Even though most individuals with 45, X/46, XY MGD have a male gender identity, MGD shows various phenotypes, ranging from female phenotypes with virilization to ambiguous genitalia. We aimed to present a case report of a patient with 45, X/46, XY MGD undergoing laparoscopic prophylactic salphingoopherectomy.

Methods

We report a case of a 16-year-old phenotypic female patient who was diagnosed with MGD and referred to our clinic. A physical examination revealed underdeveloped secondary sexual characteristics with a female phenotype. The hormonal profile showed hypergonadotropic hypogonadism. Karyotype analysis showed that 70% of the cells had 45, X and 30% had 46, XY, and it found the sex-determining region Y (SRY) gene. Magnetic resonance imaging of the abdomen demonstrated a dysgenetic gonad in the abdominal cavity and a 9 mm streak gonad in the left adnexa. After counselling with the patient, family, and a paediatric psychologist, a decision was made to proceed with laparoscopic bilateral gonadectomy to mitigate the risk of malignancy. We obtained detailed informed consent after providing the family with the necessary information.

Results

Laparoscopic exploration revealed the presence of asymmetrical two streak gonads with a normal uterus and normal-appearing fallopian tubes. After determining the course of the ureters, we successfully removed the gonads and fallopian tubes with minimal bleeding. Histopathologic examination showed a fibrous and dysgenetic gonad without neoplasia and the normal tuba in the right adnexa along with a streak gonad without neoplasia and the normal tuba in the left adnexa.

Conclusions

Laparoscopic prophylactic gonadectomy is required for patients with MGD who have Y chromosome material due to the elevated risk of gonadal malignancy. This video case highlights the importance of early surgical intervention and multidisciplinary management in patients with MGD.

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A Difficult Embryo Transfer Case After Previous Conization

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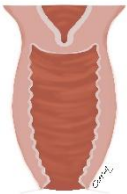
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Background

Difficult embryo transfer is a common situation in IVF practice. Often anatomical variations, the patient's weight, and even the patient's psychological state can cause difficult embryo transfer. Some previous surgical procedures can also make embryo transfer difficult. In this case, we planned to present how the embryo transfer of a patient who had undergone cervical conization twice and whose external cervical os could not be observed due to amputation of the cervix, can be performed vaginally and the stages before embryo transfer.



Methods

A 37-year-old patient who had previously been concise twice with CIN 1 and CIN II diagnoses applied to our clinic with the complaint that the embryo transfer catheter could not be placed from the cervical os to the uterus and the transfer was cancelled. During the patient's examination, the external cervical os could not be observed and it was seen that the vaginal mucosa completely covered the excised cervical tissue. A 15 mm section of the cervix could be observed in transvaginal ultrasonography. An attempt was made to reach the external cervical os and enter the uterine cavity with office hysteroscopy, but it was unsuccessful. Then, the patient underwent laparotomy. A vertical incision was made from the abdomen to the uterus and the cervix from the anterior. After entering the uterine cavity, the vagina was entered under hysteroscopy guidance, and the paediatric Foley catheter was removed from the vagina with the balloon part facing the uterine cavity. At the same time, abdominal cerclage was performed for cervical insufficiency. After approximately one month of sedation anaesthesia, the Foley catheter was removed from the cavity and an IUD (intrauterine device) was placed in its place.

Results

Approximately 4 months later, the patient was scheduled for artificial frozen embryo transfer. On the 2nd day of menstruation, the IUD was removed under anaesthesia, and the cavity was entered with a trial catheter, and sutures were placed around the trial catheter at the 3 and 9 o'clock positions. The catheter was removed on the same day. On the 17th day of induction, the patient's embryo transfer could be easily performed under the guidance of the sutures.

Conclusions

Previous cervical operations such as conization can cause serious difficulties especially in IVF treatments during the embryo transfer phase. Hysteroscopy and surgical interventions performed before the transfer will make the transfer easier

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Laparoscopic Hysterectomy for Enlarged Uterus: Resident as Primary Surgeon

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Background

We present a video case of a 48-year-old patient with a large type 3 myoma undergoing laparoscopic hysterectomy. The patient had no significant comorbidities or surgical history and presented with abdominal pain, constipation, and frequent voiding. Transvaginal ultrasound showed a uterus measuring 142 x 98 mm and a 68 x 91 mm type 3 myoma, with additional smaller type 4 myomas. Cytology, HPV testing, and endometrial sampling were unremarkable.

Methods

A 10 mm trocar was placed at the Lee-Huang point. Two 5 mm trocars were placed cranio-medial to both anterior superior iliac spines, and a third 5 mm trocar was inserted left of the umbilicus. The uterus extended to the umbilical level. After ligation of the round ligament and posterior dissection of the broad ligament, the retroperitoneal space was opened to visualize the ureter. The bladder was dissected from the vesicouterine space. The uterine artery was ligated at its origin from the internal iliac artery due to the expected technical difficulty. A 5 mm tenaculum was used to aid vaginal cuff incision and paracervical dissection.

Results

Given the large size of the uterus, an enucleation procedure was performed to facilitate vaginal removal. The vaginal cuff was closed with 2.0 V-LAC suture, and digital inspection confirmed closure. There were no intraoperative or postoperative complications.

Conclusions

Laparoscopic hysterectomy for large type 3 myomas can be safely performed with careful dissection and strategic vascular control. The patient was discharged on postoperative day 1 without complications.

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Laparoscopic diagnosis of peritoneal tuberculosis mimicking carcinomatosis in an adolescent: a clinicopathological dilemma

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Background

This case highlights the indispensable role of laparoscopic evaluation in differentiating pulmonary tuberculosis (PTB) from malignant processes, particularly in adolescent populations where malignancy would be exceptional. We propose a standardized diagnostic algorithm incorporating laparoscopic findings with advanced molecular techniques for optimal management of such challenging cases

Methods

We present a paradigmatic case of a 15-year-old nulliparous female without significant medical history who presented with a 3-month history of progressive pelvic pain and abdominal distension.

Results

Initial clinical evaluation revealed significant ascites (flank dullness, shifting dullness) with no palpable masses. Serum CA-125 was elevated at 95.56 U/mL (normal <35) with normal carcinoembryonic antigen levels.

Pelvic Computed Tomography scan demonstrated pathognomonic features of peritoneal carcinomatosis, including omental caking (mean thickness 12mm), diffuse peritoneal nodularity (largest nodule 8mm), and complex ascites (depth 9cm). Both ovaries appeared heterogeneously enlarged (right 4.5×3.2cm, left 4.1×2.8cm) with preserved architecture. Diagnostic laparoscopy revealed extensive peritoneal involvement with over 3L of straw-coloured ascites.

Critical histological examination of multiple peritoneal biopsies demonstrated confluent epithelioid granulomas with Langhans-type giant cells and central caseous necrosis. Ziehl-Neelsen staining was negative, but mycobacterial PCR later confirmed *Mycobacterium tuberculosis* complex.

Conclusions

This case highlights the indispensable role of laparoscopic evaluation in differentiating PTB from malignant processes, particularly in adolescent populations where malignancy would be exceptional. We propose a standardized diagnostic algorithm incorporating laparoscopic findings with advanced molecular techniques for optimal management of such challenging cases

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Video in ePoster

Unicornuate uterus with a remnant uterus laparoscopic management

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Background

A 14-year-old girl presented to us with complaints of monthly cyclic pelvic pain with her first menstruation.

Methods

In the upper and lower abdomen MRI, a unicornuate uterus, a remnant uterus and a single kidney were seen. Diagnostic hysteroscopy and laparoscopy were planned.

Results

Diagnostic hysteroscopy revealed a single cervix, a half-uterine cavity, and a single tubal ostium. Diagnostic laparoscopic examination revealed a functional hemiuterus with a cervix in the right pelvic wall and a functional remnant uterus without a cervix in the left pelvic wall. Left salpingectomy and hysterectomy of remnant uterus were performed.

Conclusions

There are many subtypes of Mullerian anomalies. Diagnosis can be made with TV USG, MRI imaging, diagnostic hysteroscopy and laparoscopy. The ideal treatment is determined by taking into consideration whether the remnant uterus is communicating and functional.

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Robotic V-Notes Salpingo-Oophorectomy

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Background

Robotic transvaginal natural orifice transluminal endoscopic surgery (vNOTES) is gaining popularity in gynaecologic surgery, primarily for hysterectomy and combined procedures. However, its use for isolated adnexal interventions, such as salpingo-oophorectomy, remains underreported. This case demonstrates the feasibility and safety of robotic vNOTES for isolated adnexal surgery.

Methods

A 55-year-old postmenopausal woman with a symptomatic, 5.5 cm left ovarian cyst was selected for robotic vNOTES salpingo-oophorectomy. After standard preparation, the cervix was grasped with tenaculum clamps, and a posterior colpotomy was performed. Vaginal retractors were placed to expose the posterior fornix, and peritoneal entry was achieved transvaginally. A vNOTES-specific access port was inserted, allowing docking of the da Vinci robotic system. The vessel sealer and fenestrated bipolar forceps were utilized for adnexal dissection. The left adnexa was removed in an endobag through the vaginal port, and the colpotomy incision was closed with a 0 barbed suture.

Results

The procedure was completed without intraoperative complications. Estimated blood loss was less than 50 mL. Operative time was 25 minutes. The patient experienced minimal postoperative pain, was discharged within 24 hours, and had an uneventful recovery. Final pathology revealed a benign serous cystadenoma.

Conclusions

This case supports the growing body of evidence that robotic vNOTES is a feasible and safe approach for isolated adnexal surgery. The robotic platform offers enhanced dexterity, improved visualization, and ergonomic benefits in confined transvaginal spaces. Moreover, compared to conventional vNOTES, the learning curve for robotic vNOTES appears shorter and more intuitive due to the familiarity of the console-based interface and wristed instrumentation—making it a significant advantage for broader surgical adoption. Robotic vNOTES may thus expand minimally invasive options for select adnexal indications, warranting further prospective evaluation.

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Demonstration and step-by-step laparoscopic repair of isthmocele

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Background

According to the latest statistics, the caesarean section rate in our country is approximately 50%. Following caesarean delivery, nearly half of all patients develop an anterior uterine wall defect to some extent, which may present with clinical symptoms such as postmenstrual bleeding, dyspareunia, infertility, and recurrent infections.

Methods

In this video presentation, we would like to share the case of a patient who presented to our centre with complaints of abnormal uterine bleeding. Her medical history revealed two previous caesarean sections. She was diagnosed with an isthmocele, and laparoscopic isthmocele repair was planned.

1. The uterine cavity was evaluated preoperatively using saline infusion sonography, which revealed a broad-based isthmocele located at the caesarean scar site. The overlying myometrial thickness was measured as 1.6 mm.
2. Hysteroscopic assessment clearly visualized the isthmocele.
3. Upon laparoscopic entry into the abdominal cavity, adhesions between the bladder and uterus due to previous caesarean sections were noted.
4. We began the dissection to separate the bladder and uterus, proceeding from lateral to midline using both sharp and blunt techniques.
5. To improve visualization and facilitate bladder mobilization, the bladder peritoneum was suspended to the anterior abdominal wall.
6. With the assistance of a bougie advanced from the cervix into the uterine cavity, the isthmocele site was identified.
7. The defect area was resected to reach healthy myometrial tissue.
8. The resulting myometrial defect was closed continuously using barbed sutures.
9. After confirming haemostasis, the procedure was completed.

Results

Laparoscopic approach is safe and effective for treatment of uterine isthmocele.

Conclusions

Laparoscopic approach is safe and effective for treatment of uterine isthmocele.

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<https://player.vimeo.com/video/1123276692?autoplay=1>

Bilateral Dermoid Cystectomy: Haemostatic techniques and Preventing Chemical Peritonitis

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Background

Ovarian dermoid cysts account for approximately 15% of ovarian neoplasms and commonly present in young women for whom fertility is an important consideration. This is especially true in the 10-15% of cases where cysts present bilaterally.

Surgical techniques to prevent cyst rupture, limit the use of diathermy to healthy ovarian tissue and minimise contamination when rupture does occur are key in achieving positive outcomes.

Methods

In this video a right dermoid cyst is removed intact, and haemostasis achieved with an argipressin soaked swab. The left dermoid cyst is inadvertently ruptured intra-operatively and its contents absorbed with tonsil swabs and the pelvis carefully cleaned to reduce the risk of chemical peritonitis.

Results

We have demonstrated several techniques that can be employed to perform a successful dermoid cystectomy and manage complications such as bleeding and cyst rupture.

Blunt dissection with non-traumatic laparoscopic instruments, tonsil swabs and counter-traction can help peel the cyst from the capsule. Some pin-point diathermy may be required to achieve haemostasis, but the large area of the cyst bed can be treated by using a tonsil swab soaked in argipressin which is removed at the end of the procedure.

In the event of cyst rupture, inserting a tonsil swab inside the cyst to absorb the contents can be considered to avoid contamination of the pelvis and abdomen. This technique may be advantageous to suction, especially in dermoid cysts due to their viscous or solid content.

Conclusions

A clean dermoid cystectomy can be achieved with careful blunt dissection. Healthy ovarian tissue should be protected from thermal injury and argipressin is a useful tool for this. When cyst rupture cannot be avoided, swabs may reduce contamination more effectively than suction.

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Laparoscopic Excision of an Intact Giant Paraovarian Cyst: A Case Report

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Background

Giant paraovarian cysts, defined as cystic masses exceeding 150 mm, are relatively rare adnexal tumours that can lead to significant clinical symptoms, primarily due to their compressive effects on adjacent organs or complications such as pain, torsion, or rupture. Definitive diagnosis typically relies on surgical exploration as imaging alone may not differentiate these cysts from other adnexal masses adequately. Surgical excision remains the only effective treatment; however, minimally invasive laparoscopic techniques are infrequently employed for larger cysts, primarily due to the technical challenges they present and the heightened risk of spillage during cystectomy. This report aims to highlight a successful case of laparoscopic excision of a giant paraovarian cyst while maintaining its integrity, emphasizing the surgical technique's feasibility and potential.

Methods

The case highlights a 21-year-old nulligravid female who presented with right lower quadrant pain and gradually increasing abdominal distension over the past year. Imaging studies, including a Computed Tomography (CT) scan and transvaginal ultrasound, revealed a large cystic mass consistent with a paraovarian cyst. The patient underwent laparoscopic surgery, where careful intraoperative techniques were employed, including meticulous dissection and the use of a specimen retrieval bag to ensure the cyst was removed intact without rupture.

Results

The patient underwent laparoscopic surgery, wherein the primary trocar was inserted in the middle upper abdomen (Lee Huang point) under direct visualization. Intraoperatively, the superior pole of the mass was found adjacent to the liver and gallbladder, and it measured 26.0 x 18.0 x 10.0 cm. Meticulous enucleation from the mesosalpinx was performed via blunt and sharp dissection, alternating between laparoscopic scissors and gentle sweeping motions. The cyst was enucleated intact without spillage, and a large specimen bag was introduced to facilitate the retrieval of the cyst. The patient's bed was tilted from left to right to aid in positioning the cyst inside the bag, and the specimen was decompressed and extracted through the primary trocar site. The defect was sutured post-extraction to prevent adhesion formation from the raw areas. The estimated blood loss is 40 cc.

Conclusions

Traditionally, large adnexal cysts extending above the umbilicus are managed through laparotomy. However, this case report demonstrates the successful laparoscopic excision of a giant paraovarian cyst, highlighting that with the application of advanced surgical techniques, intact removal is not only feasible but also reinforces the potential of minimally invasive methods in managing substantial adnexal lesions. While there are no strict size limitations for laparoscopic surgery on large benign adnexal masses, the success of such procedures relies heavily on the surgeon's expertise and experience. Therefore, meticulous preoperative assessment and the development of surgical skills are critical in optimizing outcomes for these complex cases.

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Complete septet uterus with septate cervix and longitudinal vaginal septum hysteroscopic management

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Background

A 36-year-old patient with gravida 2, parity zero, and 2 abortions.

TV USG showed total uterine septum, and speculum examination showed total vaginal septum.

Total uterovaginal septum was observed in MRI.

Methods

First, both cavities and septum were visualized with diagnostic hysteroscopy.

15 French bipolar hysteroscopy vaginal and uterine septum resection was performed.

The procedure was completed with a 26 French bipolar hysteroscope because the cavity could not be sufficiently distended due to fluid leakage from the cervix.

Results

Total vaginal and uterine septum resection was performed with hysteroscopy.

The operation was completed in approximately 30 minutes, using approximately 5000 cc of physiological serum fluid, with a fluid deficit of approximately 750 cc.

Conclusions

Hysteroscopy is a minimally invasive surgical technique that is less painful and allows a quick return to daily life. Particularly in patients with recurrent pregnancy loss, resection of the septum is important to reduce the risk of fetal growth retardation and placental abruption.

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Laparoscopic hysterectomy followed by özerkan - Modified sacrocolpopexy in a high-risk oncological patient

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Background

To demonstrate a mesh-free sacrocolpopexy technique (Özerkan modification) performed following laparoscopic hysterectomy in a patient with apical pelvic organ prolapse and a strong family history of gynecologic malignancies.

Methods

A 57-year-old woman with symptomatic uterine prolapse and apical descent was evaluated. Her family history was notable for ovarian and endometrial cancer (mother and sister), and she requested prophylactic surgery. Laparoscopic hysterectomy was performed, preserving the sacrouterine ligaments. The vaginal cuff was closed in two layers using 1 Vicryl. A sulcus was prepared by opening the retroperitoneal space from the sacral promontory to the vaginal apex. A mersilene tape suture was used to suspend the cuff bilaterally to the promontory using Prolene sutures. The sutures were reinforced and retroperitonealised by closing the peritoneum with Vicryl.

Results

The procedure was successfully completed laparoscopically without intraoperative complications. Total operative time was within standard limits and estimated blood loss was minimal. The patient recovered uneventfully and was discharged on postoperative day 2. At 6-week follow-up, pelvic examination revealed well-supported apical compartment without evidence of recurrence or mesh-related complications. The patient reported high satisfaction and no symptoms of pelvic pressure, bulge, or urinary dysfunction. The functional outcomes were favourable, with preserved anatomical support and no need for reintervention.

Conclusions

The Özerkan-modified sacrocolpopexy represents a viable, mesh-free alternative for apical prolapse repair in patients undergoing concomitant hysterectomy, particularly in those with oncologic risk factors. This technique preserves native support structures, reduces potential mesh-related complications, and ensures durable apical support. Our experience suggests that the Özerkan modification can be safely integrated into routine surgical practice and may be particularly advantageous in patients requiring individualized, risk-reducing approaches.

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Advanced Laparoscopic Treatment of Endometriosis: Bilateral Endometriomas, Right Uterosacral DIE, and Bladder Dissection

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Background

A detailed surgical demonstration of bilateral endometriomas complicated by right uterosacral deep infiltrative endometriosis (DIE) and bladder dissection, emphasizing ovarian reserve preservation and postoperative adhesion prevention.

Methods

Prior to surgery, the patient underwent oocyte cryopreservation. Surgical intervention was performed to address symptoms of dysmenorrhea, dyschezia, and urinary frequency. The left-sided endometrioma was managed through partial excision with limited bipolar coagulation, while the right-sided endometrioma was treated solely with aspiration, followed by the removal of deep infiltrative endometriosis from the right uterosacral ligament and bladder dissection. Special attention was given to preserving ovarian reserve throughout the procedure. To minimize postoperative adhesion formation, both ovaries were sutured to the anterior abdominal wall using delayed absorbable sutures at the conclusion of surgery.

Results

The surgical technique effectively alleviated the patient's symptoms while preserving ovarian reserve and restoring anatomical functionality. The use of delayed absorbable sutures significantly minimized the risk of postoperative adhesions.

Conclusions

This tailored surgical approach represents a valuable strategy for managing complex cases of endometriomas and deep infiltrative endometriosis (DIE), ensuring symptom resolution, ovarian reserve preservation, and adhesion prevention.

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Laparoscopic Hysterectomy for Multiple Fibroids: A Dual-Resident Surgical Approach under expert supervision

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Background

We report a notable case of a laparoscopic hysterectomy performed without complications on a markedly enlarged, myomatous uterus. Two clinical residents conducted the procedure under the supervision of an experienced specialist. The patient was a 60-year-old postmenopausal woman who presented with postmenopausal bleeding and constipation. Imaging studies revealed a globally enlarged uterus due to multiple uterine fibroids.

Methods

Preoperative transvaginal ultrasonography identified multiple leiomyomas: two We report a notable case of a laparoscopic hysterectomy performed without complications on a markedly enlarged, myomatous uterus. Two clinical residents conducted the procedure under the supervision of an experienced specialist. The patient was a 60-year-old postmenopausal woman who presented with postmenopausal bleeding and constipation. Imaging studies revealed a globally enlarged uterus due to multiple uterine fibroids.

Results

The laparoscopic approach was initiated with the placement of a 10 mm trocar at the Lee–Huang point, complemented by three 5 mm accessory trocars. The round ligament was ligated, and the anterior and posterior leaves of the broad ligament were opened to access the retroperitoneal space and identify the ureter. The bladder was carefully dissected and lateralized. The infundibulopelvic ligament, uterine arteries, and paracervical tissues up to the level of the uterosacral ligaments were ligated. Circumferential colpotomy was performed using unipolar cautery, and the uterus was removed transvaginally despite the limited visual field. Vaginal cuff closure was achieved with a continuous 2-0 V-Loc suture. Digital examination confirmed complete closure. The patient had an uneventful postoperative course and was discharged in stable condition on postoperative day one.

Conclusions

This case underscores that laparoscopic hysterectomy for a significantly enlarged uterus due to multiple fibroids can be performed safely and effectively by resident surgeons when conducted under appropriate preoperative planning and expert supervision. It highlights the feasibility of advanced minimally invasive gynaecologic surgery in a training environment without compromising patient safety or outcomes.

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Robotic nerve sparing excision of uterosacral endometriosis and intrauterine Indocyanine green dye tubal patency test.

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Background

Endometriosis is a chronic disease that can lead to pain, infertility, and menstrual disorders. Laparoscopic surgery is the gold standard for diagnosis and treatment. Robotic assisted laparoscopic surgery provides additional precision and enhances the ability to perform complex surgeries with a lower complication rate. This video demonstrates the excision superficial peritoneal endometriosis using the Da Vinci Robotic system and the application of ICG dye to check for tubal patency through trans cervical injection.

Methods

A stepwise inspection of the abdomen and pelvis was performed. Diagnostic robotic assisted laparoscopic surgery identified a superficial endometriotic lesion on the right and left uterosacral ligaments. A linear incision was performed on both side walls and the ureter was identified and dissected away from the lesion. The inferior hypogastric plexus was additionally identified and dissected away from the lesion. The procedure was performed using a robotic bipolar forceps and monopolar scissors. Diluted Indocyanine green dye was injected through an intrauterine cannula and the spill was observed using the firefly system.

Results

The peritoneum, including the lesion was excised fully with high precision and without any complications. The blood loss was nil. The dye test was performed with the ability to visualize the dye spill on both sides.

Conclusions

Robotic assisted laparoscopic surgery provides an ergonomic setup and high precision surgical approach for the surgical management of endometriosis.

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Expert strategy for Endometriosis surgery

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Background

Endometriosis, a chronic gynaecological condition affecting millions worldwide, presents significant challenges in diagnosis and management. Surgical intervention remains a cornerstone in the treatment algorithm, necessitating precise techniques for exposure optimization and anatomical restoration to achieve favourable outcomes.

Methods

This video abstract aims to explain the complexities of endometriosis surgery, specifically focusing on two pivotal aspects: exposure techniques and meticulous anatomical restoration. The objective is to provide a comprehensive visual guide for surgeons seeking to refine their skills in endometriosis management.

What was done:

The video demonstrates the stepwise approach to endometriosis surgery, beginning with exposure optimization strategies. Techniques such as Trendelenburg positioning, bowel retraction, and the T lift manoeuvre are highlighted, showing their role in facilitating improved visualization and access to pelvic structures.

Subsequently, the video transitions to the process of identifying and restoring anatomical structures compromised by endometriotic lesions. Surgical manoeuvres for opening surgical spaces, identifying pathological anatomy, and excising nodules are intricately illustrated, emphasizing precision and meticulousness.

Results

Through the detailed portrayal of surgical techniques, viewers gain insights into the complexity of endometriosis surgery and the critical role of exposure optimization and anatomical restoration. By implementing these strategies, surgeons can achieve enhanced surgical outcomes, reduced risk of complications, and improved patient satisfaction.

Conclusions

this video abstract serves as a valuable educational resource for surgeons engaged in the management of endometriosis. By providing a comprehensive overview of exposure optimization and anatomical restoration techniques, it aims to empower surgeons to navigate the complexities of endometriosis surgery with confidence and proficiency, ultimately improving patient care and outcomes.

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Laparoscopic approach to tubal ectopic pregnancy

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Background

To demonstrate the surgical principles and essential steps of laparoscopic salpingectomy in the management of tubal ectopic pregnancy.

Methods

Step-by-step video demonstration of the laparoscopic approach in a case of tubal ectopic pregnancy

Results

A 39-year-old woman presented with clinical signs of ectopic pregnancy. Her preoperative haemoglobin level was 9.3 g/dL. Laparoscopic salpingectomy was performed under general anaesthesia. the abdominal cavity was insufflated using a Veress needle, and four trocars were inserted through the umbilical, suprapubic, and bilateral lower quadrants. The left fallopian tube was distended, indicating a tubal ectopic pregnancy. It was excised using an advanced energy device. The left fallopian tube was placed in an endobag and removed through the suprapubic trocar. Haemostasis was confirmed, and the procedure was completed without complications. Later diagnostic uterine curettage was performed. Histopathology confirmed ectopic pregnancy in the left tube, and the endometrial sample showed gestational changes.

Conclusions

Laparoscopic salpingectomy is a safe and effective minimally invasive method used in the surgical management of tubal ectopic pregnancy. It offers several advantages, including reduced postoperative pain, shorter hospital stays, and faster recovery compared to open surgery. This step-by-step video demonstrates the main surgical steps and important technical details.

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Laparoscopic tuboovarian abscess ureterolysis and intestinal adhesiolysis surgery with appendectomy

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Background

Laparoscopic tuboovarian abscess ureterolysis and intestinal adhesiolysis surgery with Appendectomy

Methods

51Y P2 VD

The patient applied with complaints of pelvic pain and bloating.

GE Right adnexial 7cm mass lesion identified on examination.

Pelvic MRG A space-occupying lesion measuring 8x7x5cm containing cystic and solid components is noted in the right adnexal area. CA125 126 PET Heterogeneously increased FDG uptake (SUVmax: 19) was observed in a mass lesion compatible with primary malignancy, measuring approximately 60x55 mm in size in the axial plane in the right adnexal region and containing cystic and solid components.

Results

Operational notes:

During exploration, it was observed that the uterus was of normal size, the left ovary and tube were normal. Right adnexial tubo-ovarian abscess mass lesion, sigmoid colon, jejunal loop and appendix were conglomerated and adhered to the fossa ovarica and right pelvic side wall. The sigmoid colon, jejunal loop and appendix were dissected from the tubo-ovarian abscess with sharp and blunt dissections. Then, the posterior leaf of the ligamentum latum was opened on the right and the retroperitoneal space was entered. The ureter was lateralized with blunt dissections from medial leaf of broad ligament. Uterus, bilateral tubes and ovaries were removed vaginally. Appendix appeared inflamed appendectomy was performed. Frozen section result was reported as "BENIGN, INFLAMMATION FINDINGS" Air leak test was performed, colon and jejunal loop was determined secure with intact serosal membranes.

Note; during appendectomy procedure we used 10mm umbilical trocar for Hem-o-loc entry. Upper 5mm trocar used for 5mm optic camera.

Conclusions

Right adnexial mass lesion mimicking malignancy. The abscess lough was limited by the surrounding tissues. Therefore, systemic inflammation findings were suppressed. The first choice for treating pelvic abscesses is usually broad-spectrum antibiotics. However, in chronic cases, as such in our case, surgical intervention is necessary for definitive treatment.

<https://player.vimeo.com/video/1085825934?autoplay=1>

Laparoscopic Excision of Deep Infiltrating Endometriosis (DIE) : Ureterolysis, Ovarian Suspension and Haemostatic techniques

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Background

Deep infiltrating endometriosis (DIE) frequently distorts normal anatomical planes through fibrosis and scarring, complicating surgical dissection. An effective approach to navigating these cases is to start dissection from the normal tissue away from the disease and then work our way towards the endometriotic nodule. Vascular injury during this surgery is a rare complication.

Methods

This video demonstrates an approach to laparoscopic excision of DIE of the lateral pelvic compartment. We focus on techniques for ureterolysis, ovarian suspension and haemostatic strategies for vascular injury. We also present the treatment of an ovarian endometrioma.

Results

In this case of severe DIE, ureteral identification was initially challenging. Opening the pelvic sidewall and performing ureterolysis provided critical exposure.

During the dissection of endometriosis on the left pelvic side wall, brisk bleeding occurred from a vessel associated with the infundibulopelvic (IP) ligament. The first step in managing haemorrhage is to expose the affected area without excessive traction. This is achieved through ovarian suspension with a non-braided suture. A straight needle was introduced into the abdominal wall lateral to the inferior epigastric vessels and below the lateral ports. The needle was passed through the ovary and retrieved adjacent to its insertion and suture secured outside the abdominal wall. An absorbable braided suture was then used to ligate the bleeding vessel. This technique allowed conservation of the ovary which was desired in this case. An oophorectomy maybe considered if conservation of the ovary was not a priority.

We also demonstrated the use of haemostatic powder which is effective for minor ooze or capillary bleeds especially in areas where thermal spread to the surrounding structures is of a concern.

We used fenestration and ablation technique for the treatment of endometrioma by creating a small window in the cyst wall and then using bipolar diathermy for ablating the inner lining of the cyst.

Conclusions

Sigmoid mobilisation and ureterolysis are key components when attempting excision of DIE of the lateral compartment. Ovarian suspension is a simple and useful technique that improves vision and accessibility. While rare, vascular injury must be anticipated and managed with sound surgical technique. Fenestration and ablation is a suitable technique for treatment of endometrioma.

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Intraabdominal Abscess Extending from the Vaginal Cuff to the Sigmoid Colon: A Rare Posthysterectomy Complication

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Background

Vaginal cuff abscesses are a rare but significant posthysterectomy complication, with an incidence ranging from 0.14% to 0.37%. Patients presenting with posthysterectomy pelvic pain, bleeding, or vaginal discharge may have vaginal cuff dehiscence, abscess, cellulitis, or hematoma. If diagnosis is unclear and symptoms persist, laboratory tests and imaging are required. Stable patients with vaginal cuff abscesses are initially treated with antibiotics, with the therapeutic approach guided by history and physical findings. However, broad-spectrum antibiotics are not universally recommended for hemodynamically unstable patients or those who fail initial treatment or require drainage.

Methods

We present the case of a 51-year-old woman with a history of vaginal total hysterectomy and bilateral salpingectomy performed 7 months ago, who presented with pelvic pain. Laboratory tests showed elevated acute phase reactants, and transvaginal ultrasound revealed a 64 × 47 mm abscess behind the vaginal cuff. Despite initial treatment with broad-spectrum antibiotics (gentamicin, metronidazole, tazobactam, and meropenem), clinical and laboratory markers showed minimal improvement. In light of persistent symptoms and limited response to medical treatment, surgical exploration via laparoscopy was deemed necessary.

Results

Laparoscopic exploration revealed complex adhesions between the urinary bladder and sigmoid colon. After adhesiolysis, an abscess was drained behind the sigmoid colon under the ultrasound guidance, and the abscess wall and purulent membranes were removed. Additionally, an Ethibond suture from a previous McCall culdoplasty was removed. A right oophorectomy and left subtotal oophorectomy were performed due to extensive adhesions. Postoperatively, on day 10, the patient was asymptomatic with no vaginal discharge or pain. Laboratory tests showed normal WBC and negative CRP levels, indicating full recovery.

Conclusions

Vaginal cuff abscess is a rare complication after hysterectomy. In cases where antibiotics fail, a laparoscopic surgical approach should be considered, as it allows for effective diagnosis and management. The patient in this case achieved complete recovery with no further complications.

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Laparoscopic Excision of Deep Infiltrating Endometriosis (DIE): An Approach to the Pararectal Space and Fallopian Tube

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Background

Deep Infiltrating Endometriosis (DIE) affects 20% of women with endometriosis and may involve the rectovaginal septum, pararectal space, fallopian tubes and ovaries. Complete excision of visible endometriotic lesions has been shown to improve pain outcomes in patients with DIE.

Methods

This video illustrates an approach to laparoscopically excise DIE affecting both the lateral and posterior compartment. This includes ureterolysis, dissection of the pararectal space and excision of endometriosis on the fallopian tube. We also perform a tubal dye test to confirm tubal patency. Additionally, an air leak test was conducted by insufflating air into the rectum with the pelvis filled with saline, observing for bubbles to assess bowel integrity.

Results

Right-sided ureterolysis was followed by blunt and sharp dissection of the pelvic sidewall and pararectal space, enabling excision of endometriotic lesions. A peritoneal retraction pocket in the pararectal space was identified, everted under traction, and excised. Endometriosis involving the fallopian tube was excised using an ultrasonic energy device. The left-sided dissection was performed after visualizing the ureter to avoid injury. The tubal dye test demonstrated fill and spill bilaterally, confirming tubal patency. The air leak test showed no evidence of bowel compromise.

Conclusions

Effective laparoscopic management of DIE in the posterior compartment requires dissection of the pararectal space and ureterolysis. Energy use near the bowel should be minimized to reduce thermal injury risk. The presence of peritoneal retraction pockets may indicate deeper infiltration and should be excised. Whilst macroscopic endometriosis can be excised from the fallopian tube, in severe cases with significant distortion of the fallopian tube a salpingectomy maybe more appropriate. A tubal dye test is a valuable adjunct to assess functional tubal patency following excisional surgery.

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Safe Protocol for Deep Infiltrative Endometriosis In Frozen Pelvis

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Background

A 30-year-old woman, married for three years, presented with one year of infertility and deep dyspareunia. Imaging suggested bilateral endometriomas and possible bowel adhesions. AMH level was 4.83 ng/mL. On examination, uterosacral tenderness and posterior cervical pain were noted. Transvaginal ultrasound revealed kissing ovaries, with bilateral around 1 cm endometriomas and the left ovary adherent to the lateral pelvic wall.

Methods

After standard port placement and visualization, extensive peritoneal endometriotic implants were identified. The left and right endometrioma cysts were punctured and aspirated. Ureterolysis was performed bilaterally, with careful identification of both ureters. The ovaries were temporarily suspended to the abdominal wall using traction sutures to facilitate dissection. A right retrocervical nodule was palpated intraoperatively and excised. Bilateral cystectomies were completed using a fertility-sparing approach, with bipolar coagulation and suturing for haemostasis. Ovaries were repositioned anatomically and fixed to the peritoneal wall.

Results

Extensive stage III–IV endometriosis was confirmed, with obliteration of the Douglas pouch and ovarian adhesions. A firm right uterosacral nodule was excised. Postoperative follow-up showed normal ovarian follicular development (RO 4–5 AF, LO 4–5 AF), and complete resolution of pelvic pain.

Conclusions

This case illustrates the complexity of advanced endometriosis coexisting with infertility. Fertility-preserving laparoscopic excision of deep lesions and bilateral endometriomas can effectively restore ovarian function and relieve symptoms. Thorough ureterolysis and pelvic nerve evaluation are essential in such cases.

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Laparoscopic Nerve-Sparing Excision of Deep Infiltrating Endometriosis with Rectum Involvement

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Background

A 43-year-old premenopausal woman (G2P2) presented with histologically confirmed deep infiltrating endometriosis (DIE) of the sigmoid colon. The patient reported severe dysmenorrhea, non-cyclic lower abdominal pain, and intolerance to hormonal therapy. Imaging (MRI) revealed suspected DIE involving the sigmoid colon and left ovary, with partial obliteration of the pouch of Douglas. She had previously undergone laparoscopic left ovarian cystectomy and adhesiolysis (Enzian P2/O3, T0, C3). Family planning was completed.

Methods

Due to refractory pelvic pain and patient preference, a laparoscopic nerve-sparing excision of the rectal DIE was planned. The procedure aimed to preserve pelvic autonomic nerves while achieving complete excision of the endometriotic lesion.

Results

MRI findings were consistent with rectal and ovarian DIE, confirming the need for a surgical approach. A multidisciplinary strategy was adopted. Laparoscopic rectal shaving was performed without conversion or complications, preserving nerve structures and ensuring safe excision of endometriotic tissue.

Conclusions

This case highlights the feasibility and safety of laparoscopic nerve-sparing techniques in managing complex rectal DIE. A multidisciplinary approach, individualized planning, and surgical expertise are essential for optimal outcomes in such cases.

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Laparoscopic sacrocolpopexy for isolated rectocele with uterine preservation

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Background

Isolated rectocele in young women is an uncommon condition that can lead to significant pelvic floor symptoms and negatively affect quality of life. Laparoscopic sacrocolpopexy with uterine preservation is considered the gold standard for prolapse surgery. Numerous studies support its effectiveness and durability as a treatment option for isolated rectocele, providing long-term anatomical support and symptom relief while preserving fertility potential. This approach is particularly suitable for selected patients seeking a minimally invasive solution that maintains pelvic anatomy and function.

Methods

This is the case of a 45-year-old female patient with an isolated rectocele, classified as a stage 4 posterior prolapse according to the Pelvic Organ Prolapse Quantification (POP-Q) system. Laparoscopic sacrocolpopexy with uterine preservation was performed after obtaining informed consent. The video provides a concise demonstration of the procedure, including dissection of the vesicovaginal and rectovaginal spaces, identification of key anatomical landmarks for ligament dissection, and fixation of a polypropylene mesh to the anterior vaginal wall and the levator ani muscles. It also illustrates secure mesh tunnelling through the peritoneum, followed by anterior and posterior peritonisation. The authors declare no conflicts of interest.

Results

The surgery was uneventful with 2-days hospital stay, and symptoms resolved completely. No recurrence was observed at 6 months of follow-up.

Conclusions

Laparoscopic repair of posterior compartment prolapse, is an effective and minimally invasive approach that offers durable anatomical correction with low complication rates. This technique is particularly beneficial in symptomatic patients with isolated or combined posterior defects, and it can be integrated into uterine preserving prolapse surgeries.

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V-notes technique in 10 steps in cases without hysterectomy

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Background

V-notes, the acronym of vaginal natural orifice transluminal endoscopic surgery, has appeared in the recent years as a novel technique that combines both laparoscopic approach and vaginal access with a low rate of complications and an adequate security profile. In this video abstract, we aim to reassure the feasibility of V-NOTES for other gynaecological procedures that are uterus-sparing.

Methods

In this video demonstration we divided the procedure in 3 phases containing 10 steps for educational purposes:

Phase A: Trans-vaginal access to the abdominal cavity

Step 1: Posterior colpotomy

Step 2: Douglas pouch dissection

Step 3: Peritoneum opening, abdominal cavity entrance

Step 4: Colocation of single port device, positioning trocars

Step 5: Pneumoperitoneum insufflation (high flow/ 8-10 mmHg pressure)

Phase B: Laparoscopic procedure (in this case, bilateral salpingectomy)

Step 6: Identification of pelvic structures

Step 7: Coagulation and section of meso-salpinx

Step 8: Identification and control of possible bleeding points.

Phase C: Vaginal access closure

Step 9: Extraction of surgical specimen and Gel Point® disassembling

Step 10: Posterior colpotomy closure

Results

V-notes approach in selected cases has several benefits when compared to conventional laparoscopy as less postoperative pain, lower operative and hospitalization time and fewer postoperative complications

It is also described a low rate of conversion in the published literature

Conclusions

Considering new emerging surgical approaches as V-notes as it may offer several advantages over conventional laparoscopy and also provide benefits in selected patients.

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Complete laparoscopic resection of a large abdomino-uterine deep endometriotic nodule, combined with hysterectomy, mesh placement, and peritoneo-plasty.

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Background

To present the complex case of a patient with a large deep endometriotic nodule, developing from the anterior uterine wall and invading extensively the anterior abdominal wall, who was managed entirely laparoscopically.

Methods

This 42-years-old patient had a past history of a complicated previous caesarean section that resulted in two subsequent procedures to manage haemorrhage and bowel obstruction. On this occasion she presented with intractable dysmenorrhea, dyspareunia and abnormal uterine bleeding. She was diagnosed with a large anterior uterine endometriotic nodule, invading both recti abdomini muscles and the overlying rectal sheath. The uterus was fixed to the abdominal wall. Due to the inability to access hysteroscopically a hyperplastic endometrium, the patient consented to undergo hysterectomy and nodule resection.

Results

The uterus was mobilized following a bilateral lateral approach, after division of both round ligaments, and recognition of the course of both ureters. The endometriotic nodule was bisected, a guide suture was introduced to its abdominal part to facilitate manipulation, and the nodule was resected from both recti abdomini muscles, excising in the process the invaded anterior leaf of their sheath. A hysterectomy was then performed, and a mercilene mesh was placed over the large abdominal wall gap. The surrounding peritoneum was mobilized, several peritoneal flaps were created and sutured one to the other over the mesh, to completely cover it, resulting in an excellent anatomical result, followed by suspension of the ovaries. Histology confirmed the diagnosis of a deep endometriotic nodule, and that of complex endometrial hyperplasia. At six months follow-up, the patient reported complete resolution of her pain symptoms.

Conclusions

A pure laparoscopic procedure is rarely indicated for deep endometriotic nodules of the anterior abdominal wall. When the uterus is concurrently involved, this approach may offer specific advantages in the effective treatment of this complex pathology.

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Shaving of a Large Ureteric Nodule

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Background

Laparoscopic excision of ureteric endometriosis is a complex, minimally invasive procedure that requires meticulous preoperative planning and surgical precision to preserve ureteral function and prevent complications. The procedure involves identification, dissection, and excision of endometriotic lesions affecting the ureter, which can be extrinsic (surrounding the ureter) or intrinsic (infiltrating the ureteric wall)

Methods

Preoperative planning includes imaging – Magnetic Resonance Imaging (MRI), CT Urogram, Intravenous Pyelography, to assess the extent of ureteric involvement and degree of hydronephrosis-hydroureter. Renal function tests and cystoscopy with ureteric stenting, especially in cases of intrinsic disease is important. A Multidisciplinary approach is warranted. It is crucial to preserve ureter's blood supply, the adventitial vessels to avoid potential ischemic compromise

Results

Ureteric endometriosis accounts for less than 1% of all endometriosis cases and may be classified as intrinsic or extrinsic, with the latter being more common. Patients often present with vague symptoms such as pelvic pain, dysmenorrhea, or may be asymptomatic. Sometimes, cyclical urinary symptoms like flank pain or recurrent urinary tract infections are reported. Surgical intervention is the gold standard, with ureterolysis, ureteric nodule shaving, segmental ureterectomy, or ureteric reimplantation depending on the extent of involvement (Boari Flap, Psoas Hitch).

Conclusions

Ureteric endometriosis is an uncommon but important differential diagnosis in women presenting with nonspecific pelvic or flank pain. Due to the risk of silent kidney damage, early recognition and a multidisciplinary approach towards management are crucial. Surgical treatment remains the standard of care and may be challenging, particularly in cases of obstruction or renal impairment. The procedure ideally takes place jointly with Endometriosis Specialist and Urologist both present during the procedure.

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Laparoscopic myomectomy by using temporary uterine artery occlusion by Bulldog clamp

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Background

We aimed to demonstrate laparoscopic myomectomy technique employing temporary uterine artery occlusion using Bulldog clamps or suture loop. The objective is to reduce intraoperative blood loss and maintain optimal visualization during fibroid enucleation, particularly in patients desiring fertility preservation.

Methods

The video article presents the case of a 39-year-old woman with complaints of abnormal uterine bleeding and a desire for future fertility. Transvaginal ultrasound revealed a 74*68 mm intramural fibroid. The patient underwent laparoscopic myomectomy with bilateral temporary uterine artery occlusion using a Bulldog vascular clamp and a suture loop.

Results

Laparoscopic myomectomy was successfully performed with temporary occlusion of the uterine arteries. The fibroid was enucleated and removed transvaginally via posterior colpotomy using an endobag. No significant intraoperative complications occurred. Estimated blood loss was minimal, and operative time was within acceptable limits. The patient had an uneventful postoperative course and was discharged on postoperative day 1.

Conclusions

Temporary uterine artery ligation using Bulldog clamps appears to be a safe and effective method in reducing intraoperative blood loss and enhancing surgical field visualization during laparoscopic myomectomy. This technique may be particularly beneficial in cases where vasoconstrictive agents are contraindicated or where fertility preservation is a priority.

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In situ methotrexate injection as the primary treatment for caesarean scar pregnancy: two case reports

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Background

Caesarean scar pregnancy is a rare form of ectopic pregnancy, increasingly diagnosed due to rising caesarean rates and improved early imaging. If untreated, it can lead to severe complications. While methotrexate is a common treatment, data on ultrasound-guided in situ injection remain limited. We present a successfully managed case using this conservative approach.

Methods

A 42-year-old woman, G2P1, with a seven-week caesarean scar pregnancy and no prior prenatal follow-up, was admitted for treatment. Transvaginal ultrasound revealed an empty uterine cavity, closed cervix, and a gestational sac with positive foetal heart rate implanted in the caesarean scar niche, with low vascularity (PSV 26 cm/s). Initial serum β -hCG was 19,524 IU/L. Given the patient's desire for future fertility, an ultrasound-guided in situ injection of 60 mg methotrexate was performed using a double-lumen oocyte retrieval needle under local anaesthesia.

Results

The procedure was well tolerated without complications. Serial β -hCG levels demonstrated a consistent decline, dropping to 2 IU/L by day 36. A follow-up ultrasound at five weeks post-injection confirmed complete resolution of the pregnancy.

Conclusions

Ultrasound-guided in situ methotrexate injection appears to be a safe and effective conservative treatment for caesarean scar pregnancy in selected cases, especially in women desiring future fertility.

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Challenging Endometriosis Surgery in the Context of Coexisting Adenomyosis and Bilateral Endometrioma

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Background

The prevalence of endometriosis among women of reproductive age ranges between 2% and 10%, but it may increase up to 50% in women with chronic pelvic pain and/or infertility.

Surgical techniques used in the management of endometriosis vary depending on the location and extent of the lesions. For instance, in cases of deep infiltrating endometriosis, more complex procedures such as sigmoidectomy or rectal resection may be required. A meticulous surgical approach aims to achieve complete excision of the lesions while preserving adjacent organs.

Particularly in surgeries involving the bowel, the risk of fistula formation is relatively elevated. Additionally, when addressing endometriotic foci on the ureters or uterosacral ligaments, there is a risk of ureteral injury or thermal damage. Therefore, such operations are recommended to be performed by surgeons with expertise in endometriosis surgery.

Methods

A 37-year-old female patient presented to our clinic with complaints of dysmenorrhea and dyspareunia. Her medical history revealed a previous surgery for endometrioma approximately 15 years ago.

Transvaginal ultrasonography demonstrated a bilobulated, cystic lesion measuring approximately 8 cm, originating from the right adnexal region, consistent with an endometrioma. In the left adnexa, a cystic structure measuring approximately 3 cm with dense internal content, also consistent with an endometrioma, was observed. Additionally, a posterior uterine lesion measuring about 3 cm was noted, suggestive of adenomyosis. Bimanual examination revealed nodularity in the pouch of Douglas.

Due to her persistent symptoms, the patient underwent laparoscopic endometrioma cyst excision and myomectomy. She was discharged from our clinic on postoperative day 2 without any complications.

Results

During and after the surgery, the patient did not require any blood transfusions, and no surgical site infection was observed. In the postoperative follow-up period, a regression in the patient's symptoms was noted. Most importantly, the patient reported a significant improvement in her quality of life.

Conclusions

In conclusion, endometriosis surgery is a complex process that encompasses a broad spectrum of techniques and approaches. The advantages offered by laparoscopic surgery, along with the expertise of specialized surgeons, can significantly influence the success of the treatment. Given its

potential impact on women's health and the risk of possible complications, surgical intervention should always be carefully considered. It is essential that such procedures are performed by physicians with specific expertise in endometriosis surgery.

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Video in ePoster

Laparoscopic Hysterectomy

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Background

In laparoscopic surgery, anatomy and surgical dissection are important in terms of evaluating tissue planes, handling difficult cases, or evaluating and intervening in cases where a problematic situation develops, even if the case is not considered difficult. In complication management, topographic anatomy knowledge, training and experience, and the steps of applying the correct techniques are important in reducing patient morbidity and solving the problem. In this video presentation, it was planned to evaluate the hysterectomy steps and basic pelvic anatomical structures through a video presentation in a case where laparoscopic hysterectomy was performed.

Methods

CASE:

A 52-year-old patient was admitted to our clinic with postmenopausal bleeding. The patient's endometrial biopsy revealed hyperplasia, and a decision was made to perform a laparoscopic hysterectomy. The patient was discharged in good health on the first day after the operation.

Results

The patient was discharged in good health on the first day after the operation.

Conclusions

Laparoscopic hysterectomy should always be considered as the first option in patients who are scheduled for hysterectomy.

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From Uncertainty to Clarity: The Diagnostic and Therapeutic Role of Minimally Invasive Surgery in Acute Abdomen

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Background

Tubo-ovarian abscess (TOA) is a severe complication of pelvic inflammatory disease and is commonly managed with broad-spectrum antibiotic therapy. However, surgical intervention may be necessary in cases unresponsive to medical treatment. This case presentation aims to highlight the effectiveness of laparoscopic surgery in a TOA case resistant to antibiotics and to emphasize the importance of the minimally invasive approach.

Methods

A 43-year-old woman (Gravida:1 Parity:1) with a history of caesarean section and no other known comorbidities presented with signs of an acute abdomen. She had subfebrile fever, leukocytosis, elevated C-reactive protein levels, and severe abdominal and pelvic pain. The patient was hospitalized with a preliminary diagnosis of ruptured ovarian cyst, appendicitis, or ruptured tubo-ovarian abscess (TOA). Broad-spectrum intravenous antibiotics were initiated and administered for 48 hours. Due to the lack of clinical and laboratory improvement, diagnostic laparoscopy was planned.

Results

Intraoperative evaluation revealed an actively ruptured tubo-ovarian abscess (TOA) in the left adnexal region and pyosalpinx on the right side, with extensive purulent fluid present throughout the lower abdominal cavity. Consequently, a laparoscopic bilateral salpingectomy was performed, successfully excising the ruptured TOA and pyosalpinx. The postoperative course was uneventful, accompanied by rapid clinical improvement. The duration of hospital stay was minimized, aligning with the average length of 4.5 days reported in the literature for laparoscopic procedures. On the seventh day of intravenous antibiotic therapy, the patient was transitioned to oral antibiotics and subsequently discharged, completing a total antimicrobial treatment course of 14 days.

Recent studies have demonstrated that the laparoscopic approach is associated with shorter hospital stays, reduced postoperative pain, and lower complication rates compared to open surgery. Moreover, early laparoscopic intervention in antibiotic-resistant TOA cases has been reported to limit infection spread and reduce the risk of sepsis.

Conclusions

The ruptured tubo-ovarian abscess and concomitant pyosalpinx were successfully managed through laparoscopic excision, demonstrating the feasibility and efficacy of minimally invasive surgical intervention in such cases. This approach offers both diagnostic and therapeutic advantages, facilitating rapid patient recovery and reduced hospital stay. Current literature also supports the significant role of laparoscopic surgery in the management of TOA.

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Hysteroscopic management of uterine septum

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Background

To demonstrate the hysteroscopic management of a uterine septum using a standardized operative technique.

Methods

Step-by-step video demonstration of hysteroscopic management of a uterine septum using a standardized operative technique

Results

A 27-year-old woman was incidentally diagnosed with a uterine septum. Hysteroscopic resection was planned to use a standard technique. The procedure was performed under general anaesthesia with the patient in the lithotomy position. After cervical dilation, hysteroscopic entry into the cavity was performed. On initial inspection, two small submucosal fibroids (3–5 mm) were identified on the anterior and fundal walls and removed with scissors. After clear visualization of both tubal ostia, the septum was excised using scissors. The procedure was completed when a normal uterine cavity was confirmed. No complications occurred.

Conclusions

Hysteroscopic resection of a uterine septum is a safe and effective minimally invasive procedure to restore normal uterine anatomy. This video demonstrates the key steps of a standard technique. An optimal view and a step-by-step approach help reduce the risk of complications.

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Burch colposuspension technique: Laparoscopic approach

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Background

Stress urinary incontinence (SUI) is a common condition in women, often resulting from urethral hypermobility. The Burch colposuspension is a well-established surgical treatment with proven long-term efficacy. The laparoscopic approach replicates the principles of the open technique while offering the advantages of minimally invasive surgery, including reduced morbidity and faster recovery.

Methods

this is the case of 58 years old woman with no medical history , Gravida 4 Para 4 with 4 vaginal deliveries.

the main complaint was a bulging sensation in the vagina for the past year associated to occasional stress urinary incontinence (SUI) during coughing or exercise.

Physical exam has found a Stage 3 Uterine Prolapse (POP-Q) associated to an anterior compartment defect

Cough stress test positive for urine leakage

the Urodynamic testing confirms genuine stress urinary incontinence with preserved bladder compliance.

The proposed treatment was a laparoscopic sacrocolpopexy with hysterectomy associated to a Burch colposuspension.

In this video we will only show the Burch colposuspension.

Results

the operative time for the Burch colposuspension was 30 min with no blood loss.

The immediate postoperative course was uncomplicated, the patient was discharged after 3 days

At the One-month clinical control, the patient examination found no clinical recurrence of the prolapse and a negative Cough stress test.

Conclusions

Laparoscopic Burch colposuspension remains a relevant surgical option in the management of stress urinary incontinence. The technique is reproducible and provides good anatomical and functional outcomes when performed by experienced surgeons. Its minimally invasive nature supports faster recovery while preserving the efficacy of the original procedure.

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Safe laparoscopic excision of a giant borderline serous ovarian tumour during mid-pregnancy: A case-based approach

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Background

Adnexal masses are detected in approximately 1–2% of pregnancies. While most are benign and asymptomatic, large or symptomatic cysts may require surgical intervention. Laparoscopic management is increasingly favoured due to its minimal invasiveness and faster recovery, particularly during the second trimester, which is considered the safest period for non-obstetric surgery. We aim to present a case of laparoscopic excision of a giant adnexal cyst during pregnancy and discuss the surgical approach and clinical outcomes.

Methods

We report the case of a 32-year-old primigravida at 18 weeks of gestation who presented with lower abdominal pressure and pain. Antenatal imaging revealed a 30 cm cystic mass originating from the right adnexa. Given the patient's symptoms, mass size, and gestational age, a laparoscopic approach was planned. Under general anaesthesia, a 10-mm trocar was inserted via the open (Hasson) technique at the umbilicus. Two additional 5-mm trocars were placed at Palmer's point and in the suprapubic region. The gravid uterus measured approximately 18 weeks.

Results

Intraoperatively, a large cyst extending to the right upper quadrant was observed, arising from the left ovary and fallopian tube. After decompressing the cyst by aspirating approximately 7600 mL of clear serous fluid, complete excision was achieved using a LigaSure vessel sealing device. The cyst was removed through an enlarged suprapubic trocar site. Total operation time was 39 minutes, and anaesthesia duration was 55 minutes. There were no intraoperative or postoperative complications. Postoperative maternal and foetal monitoring remained stable, and the patient was discharged on postoperative day 1 without issues.

Conclusions

This case highlights that laparoscopic surgery during the second trimester, when performed with meticulous planning and technique, is a feasible and safe option for managing large adnexal masses in pregnancy. The second trimester provides optimal uterine size, reduced miscarriage risk, and more favourable operative conditions. Minimally invasive approaches offer benefits such as reduced postoperative pain, shorter hospital stay, and faster recovery. However, multidisciplinary evaluation and individualized decision-making remain crucial for optimizing both maternal and foetal outcomes.

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Hysterectomy by Vaginal Natural Orifice Transluminal Endoscopic Surgery (vNOTES) in patient presented with acute urinary retention caused by a large prolapsed pedunculated submucous myomas

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Background

Prolapsed pedunculated submucous myomas are rare benign diseases which may lead to serious complications such as urinary tract obstruction and kidney dysfunction secondary to compression to the bladder and ureters. Although there is not a standardized treatment for prolapsed pedunculated submucous myoma, surgical treatment may necessitate vaginal access. In this video we aimed to present a case report of a patient underwent hysterectomy by Vaginal Natural Orifice Transluminal Endoscopic Surgery (vNOTES) in patient presented with acute urinary retention caused by a huge prolapsed pedunculated submucous myomas.

Methods

In this video we present the case of a patient with a 9 cm degenerative necrotic myoma involving the servical canal , extending to the vagina .A 48 year old G2P2NSD2 woman with no significant medical history presented to our department with urinary foley catheter and she complained of significantly inability to completely empty the bladder .In the vaginal examination there is approximately 9 cm pedunculated submucosal myoma was located in speculum and also pelvic ultrasonography revealed an a necrotic degenerative leiomyoma protruding through to the cervical canal. We chose to employ a vNOTES hysterectomy after vaginal extraction of myoma. At the beginning of operation, myoma was clearly visualised inside the vagina and delivered through the vagina by dividing smaller pieces for easier extraction. The myoma was extracted by slicing and after we proceed to vNOTES hysterectomy.

Results

Surgical approach of pedunculated submucous myoma is succesfully completed with extraction of myoma and vNOTES Hysterectomy and bilateral salpingo-oophorectomy, The operation was completed without any surgical complication, and the patient was discharged .

Conclusions

In cases where patients with submucous pedunculated myoma which can cause bladder globe and urinary disfunction .Vaginal extraction of myoma and vNOTES hysterectomy may present as a favourable option. Vaginal approach and surgery can be chosen in such cases due to its enhancement of the surgeon's manoeuvrability.

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Expectant management of residual placenta accreta spectrum via hysteroscopy: a case report

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Background

Placenta Accreta Spectrum (PAS) is an increasingly recognized pregnancy-related condition characterized by abnormal trophoblastic invasion into the myometrium, ranging from superficial adherence (accreta) to deep infiltration (incretta) and, in severe cases, extension into adjacent organs (percreta). While hysterectomy has traditionally been the standard management, particularly in cases with extensive invasion, emerging evidence supports conservative approaches in selected hemodynamically stable patients to preserve fertility and reduce surgical risks.

Methods

Through ultrasound and hysteroscopic imaging, we present the videocase of a patient with retained placental tissue diagnosed as residual PAS. Given the patient's stable condition, an expectant management strategy was adopted, involving close clinical follow-up and serial transvaginal ultrasound with Doppler imaging. Vascular flow within the retained tissue progressively decreased and was no longer detectable by 23 weeks postpartum. At that point, an office hysteroscopic resection was planned and performed.

Results

Hysteroscopic shaving of the residual placental tissue was successfully performed. The procedure was carried out without the need for anaesthesia, and the patient reported no pain during or after the intervention. There was no intraoperative or postoperative bleeding. Complete removal of the abnormal tissue was achieved without complications. Uterine integrity was preserved, and the patient retained her reproductive potential.

Conclusions

This case demonstrates that, in carefully selected and closely monitored hemodynamically stable patients, expectant management followed by hysteroscopic resection may be a safe and effective alternative to immediate hysterectomy. This approach can reduce surgical morbidity and help optimize future reproductive outcomes.

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Visualizing vNOTES Hysterectomy: A Comprehensive Surgical Guide

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Background

This video aims to provide a detailed visual demonstration of the vaginal natural orifice transluminal endoscopic surgery (vNOTES) technique for hysterectomy. The objective is to offer a comprehensive educational resource illustrating the key surgical steps, critical anatomical landmarks, and technical nuances associated with this minimally invasive approach for novice surgeons.

Methods

The video presents a step-by-step performance of a vNOTES hysterectomy. It meticulously showcases patient positioning, the establishment of transvaginal access and pneumoperitoneum, the introduction and manipulation of endoscopic instruments through the vNOTES platform, and the systematic execution of the surgical procedure. This includes the identification and management of the uterine vasculature, the performance of the colpotomy, the detachment of the uterus, and the subsequent closure of the vaginal cuff.

Results

The video offers a clear and structured visual guide to performing a vNOTES hysterectomy. Key aspects such as the creation of adequate surgical space, systematic dissection techniques, and effective methods for hemostasis and vaginal cuff closure are demonstrated. The comprehensive visualization allows viewers to gain a thorough understanding of the pelvic anatomy and the specific instrumentation utilized in this approach. The inherent advantages of vNOTES, such as the absence of visible abdominal scars, are implicitly highlighted.

Conclusions

This comprehensive surgical video serves as a valuable educational tool for surgeons and trainees seeking to learn or refine their skills in vNOTES hysterectomy. By providing a detailed visual roadmap of the procedure, it aims to enhance surgical understanding, promote the safe and effective adoption of this minimally invasive technique, and ultimately contribute to improved patient outcomes.

<https://player.vimeo.com/video/1085856991?autoplay=1>

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Laparoscopic Management of Frozen Pelvis in a Patient with Chronic PID and Bilateral Hydrosalpinx: A Case Report

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Background

To present the clinical course, surgical challenges, and successful management of a complex case involving a 48-year-old patient with chronic pelvic inflammatory disease (PID), recurrent pelvic pain, and bilateral hydrosalpinx. The procedure—comprising pelvic abscess drainage, total laparoscopic hysterectomy, and bilateral salpingo-oophorectomy (TLH + BSO)—was completed without intraoperative complications or urinary tract injury.

Methods

A 48-year-old multiparous woman presented with a two-month history of lower abdominal pain and malodorous vaginal discharge. She also had a history of recurrent PID episodes and persistently elevated CRP levels over the past two years.

Initial pelvic ultrasound revealed bilateral adnexal cystic lesions suggestive of hydrosalpinx. Despite broad-spectrum intravenous antibiotics, her symptoms persisted. Serial laboratory tests showed fluctuating but consistently abnormal CRP and leukocyte levels that never normalized.

Upon readmission with worsening pelvic pain, diagnostic laparoscopy was planned. Intraoperative findings revealed extensive pelvic adhesions, bilateral hydrosalpinx, and an abscess in the left paracolic region, which was drained during the procedure.

The complex abscess formation—appearing as a single mass along with the uterus—was approached via broad ligament dissection. A potential space was carefully created and extended toward the ovarian fossa using a combination of sharp and blunt dissection. Infected tissue adherent to the uterus was meticulously separated by blunt dissection.

Urology consultation was requested intraoperatively. No injury was identified, but due to congenital narrowing, a prophylactic ureteral stent was placed in the left ureter.

Results

The surgery was completed successfully without complications. The uterus and adnexa were removed transvaginally. No intraoperative injury or additional pathology was observed by the consulting teams.

Postoperative monitoring showed stable hemodynamics. Leukocyte and CRP levels slightly increased postoperatively but gradually normalized. *Escherichia coli* was isolated in the pus culture, and since the strain was sensitive, ceftriaxone therapy—already in use—was continued.

Conclusions

Chronic PID with bilateral hydrosalpinx can result in extensive pelvic adhesions and complications requiring definitive surgical management. In patients with persistent symptoms despite antibiotic therapy, laparoscopic treatment with multidisciplinary support offers a safe and effective solution.

Early recognition and intraoperative management of potential risks—such as ureteral protection—are crucial for optimal outcomes. **Meticulous surgical dissection in frozen pelvis cases is essential not only for complete disease resolution but also to minimize complications and preserve surrounding anatomical structures.**

<https://player.vimeo.com/video/1085858293?autoplay=1>

Invasive ovarian mole: A rare and challenging diagnosis mimicking ectopic pregnancy

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Background

Ovarian molar pregnancy is an extremely rare form of ectopic gestation that can clinically and radiologically mimic other adnexal pathologies, including ectopic pregnancy and ovarian tumours. Early diagnosis is essential due to the risk of haemorrhage and potential for malignant transformation.

Methods

We present the case of a 32-year-old woman, with no prior medical history, who presented with pelvic pain and abnormal uterine bleeding associated with 6 weeks of amenorrhea. Clinical examination revealed hemodynamic stability, a tender abdomen, minimal vaginal bleeding, and a slightly enlarged uterus. Transvaginal ultrasound showed a normal uterus with a thin endometrium and a heterogeneous, enlarged left ovary measuring 6 cm, associated with a small amount of free fluid. Laboratory results revealed a markedly elevated plasma beta-HCG level of 250,000 IU/L. A diagnostic laparoscopy was indicated to clarify the diagnosis.

Results

Intraoperative findings included a small hemoperitoneum, a gravid-appearing uterus, and normal-appearing fallopian tubes and right ovary. The left ovary was enlarged, ruptured in places, and showed a hemorrhagic, vesicular, and heterogeneous mass adherent to the peritoneum and bowel. A left adnexectomy was performed, along with careful resection of the adherent trophoblastic tissue. The specimen was retrieved using an ENDOBAG to avoid intra-abdominal contamination. Histopathological analysis confirmed the diagnosis of an invasive mole confined to the ovary. Postoperative follow-up showed a gradual decline in beta-HCG levels and no evidence of metastatic disease on imaging.

Conclusions

Ovarian molar pregnancy is a rare clinical entity that should be considered in women of reproductive age presenting with pelvic pain, elevated beta-HCG levels, and adnexal masses. Differentiation from more common ectopic pregnancies or ovarian tumours can be challenging. Laparoscopy plays a crucial role in diagnosis and treatment. Prompt surgical management is necessary to prevent complications and ensure favourable outcomes. Long-term follow-up with serial beta-HCG monitoring is essential due to the risk of persistent gestational trophoblastic disease.

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Excision and Mesh Repair of Large Anterior Abdominal Wall Endometriotic Nodule

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Background

Abdominal wall endometriosis (AWE) is a rare and often underdiagnosed form of extrapelvic endometriosis. Patients typically present with palpable, painful, subcutaneous nodule that demonstrates cyclical exacerbation of symptoms correlated with menstruation, having gynaecological surgeries in the past, such as caesarean sections.

Methods

Differential might be challenging, considering hernias, lipomas, or neoplasms. Structured clinical assessment is essential for prompt recognition. Ultrasound and Magnetic Resonance Imaging (MRI) are valuable for determining the lesion and guiding management. A Multidisciplinary approach guided our surgical planning.

Results

Definitive diagnosis is histopathological, confirming the presence of endometriosis, as in our case. Surgical excision with clear margins remains the gold standard for treatment, offering symptom resolution and minimizing recurrences. Achieving a closure of the sheath depends on the size of the resected segment; roughly 3-5cm will close directly. Below the arcuate line there is only anterior sheath, therefore excision of the sheath will mean a fascial defect and mesh is advised if direct closure not possible. According to literature a 5-10mm excision margin from the nodule is advised. The mesh- onlay rests on top of the sheath and can be synthetic prolene mesh. Biological mesh is safe around the bowel and can be placed as sublay intra-peritoneally if there is no posterior sheath or a full thickness defect that needs to be bridged. The mesh either as onlay or sublay should extend a few centimetres beyond the defect on all margins. It should not be loose or rippled.

Conclusions

Early recognition and effective management, minimise patients' morbidity and prevent delays in care. Further research regarding optimal surgical approaches is warranted to improve outcomes. This abstract highlights the importance of considering AWE in the differential diagnosis of anterior abdominal wall masses in women with previous gynaecological surgeries, advocating for a multidisciplinary approach to diagnosis and treatment.

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Sciatic endometriosis

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Background

In this video, we demonstrate the laparoscopic management of sciatic nerve endometriosis. It presents the case of a 26-year-old woman who presented with a one-year history of right gluteal and posterior thigh pain, associated with paresthesia in the L5–S1 dermatomes. Imaging revealed a 2 × 1.2 cm lesion involving the proximal sciatic nerve at the level of the sciatic notch, with perineural oedema.

Methods

The resection of the lesion is demonstrated in this video, along with a deep understanding of the anatomy and demonstration of surgical technique to preserve the nerve fibres.

Results

Intraoperatively, a dense fibrotic endometriotic lesion encasing the lumbosacral trunk was identified. By the development of the appropriate spaces such as the iliolumbar and obturator space, the lesion was isolated from the adjacent structures and nerve. During the dissection, key neurovascular structures—including the lumbosacral trunk, sciatic nerve, sacral nerve roots, and gluteal vessels—were carefully identified, dissected and preserved.

Conclusions

Postoperatively, the patient recovered well and was discharged on postoperative day one. At four months, she reported full resolution of pain with minimal residual paresthesia.

This case highlights the utility of laparoscopic access via the iliolumbar space for safe and effective excision of deep endometriosis involving the sciatic and sacral nerves.

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Review of Fluorescence techniques for Gynecological Surgery

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Background

Fluorescence guided surgery was a great improvement in laparoscopic surgeries. Until now new techniques are being develop to improve surgery concerning safety, operative time and more precise dissections.

In a brief video review, with literature support, we show examples of those situations like ureteral painting, sentinel lymph node harvesting, real time video angiographies (tubes, ovaries, sigmoid, ureter), endometrioma wall nodule plot, use of endoluminal fluorescent devices, bladder dissection, bleeding detection, and new perspectives with this valuable help tool.

Methods

Literature review and authors video library examples of fluorescence assisted surgery in gynaecological situations.

Results

More than fifteen different surgical video situations exampling fluorescence assisted surgery with proper scientific literature support.

Conclusions

Fluorescent techniques have a wide range of applications in gynaecological surgeries, helping on identify surgical planes, ischemic areas, plot specific sites and structures improving safety, operative time and surgical precision.

<https://player.vimeo.com/video/1087563427?autoplay=1>

<https://esge.covr.be/cmdocumentmanagement/conferencemanager/documents/api/getdocument/14980/cmabstsms/0000216910/df52a202fc3558a8b87f8ba77bc7a7baf488def12bbfe8646887f3f9bc2e48dc>

Ureteral Vascularization and perfusion check with Indocyanine Green

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Background

We face the risk of ureteral injuries in very pelvic surgery, and this possibility increases in complex surgeries.

The advance of near infrared fluorescence techniques and equipment nowadays gave us more one tool to increase surgical safety.

The "ureteral painting" (intraluminal injection of Indocyanine green dye (ICG) through cystoscopy)" is a good technique to plot the ureter in complex cases but we could go far. In this video with some surgical cases, we show the evolution of that technique from the ureteral perfusion check to real time video angiographies using Near Infrared laparoscopic cameras. It's important to emphasize that we could combine techniques and the initial ureteral painting don't prohibit the use of real time video angiography during the surgery.

Methods

Video collection, literature review and explanation about ureteral injuries in laparoscopy surgeries with examples of use of Fluorescence techniques to check the perfusion and ureteral vascularization with the endovenous injection of ICG during the surgery.

Results

The use of ureteral painting technique with low dosage of Indocyanine Green Dye, generally, in the beginning of the surgery, don't prohibit the use fluorescent video angiography during the surgery

Conclusions

The use of fluorescence techniques to check perfusion and vascularization of the ureter could improve surgical safety, allowing the detection of injuries during the surgery.it could also be combined with ureteral painting technique generally performed in the beginning of the procedure.

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<https://esge.covr.be/cmdocumentmanagement/conferencemanager/documents/api/getdocument/14982/cmabstsms/0000216910/8dcd8f891eda1b847540ffd01535bb833bfa197cae4bc874e24086c8e dae13b2>

Simple Ureteral catheterization for endoluminal fluorescence during Surgery

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Background

Ureteral identification during surgery avoids urinary complications, the use of "ureteral painting" with Indocyanine Green Dye (ICG) , injected by cystoscopic approach helps real time identification with fluorescence techniques, reducing operative time by reducing unnecessary ureterolysis or reducing his extension.

In this video tutorial we teach a simple, fast a low cost technique to inject ICG in the beggining of laparoscopic surgeries using low cost and wide available equipment and materials.

Methods

After a brief literature revision, in this tutorial video, with ten detailed steps, we show our technique to perform ureteral catheterization for endoluminal ureteral painting.

With patient prepared for surgery (anaesthesia, in lithotomy position and disinfected) we inject, prior to cystoscopy two milometers os lidocaine jelly, than with a Bettochi set we perform the cystoscopic exam, using a disposable epidural catheter, we identify and introduce five centimetres of the catheter inside the ureteral ostium and inject 7.5mg of ICG, retrieve the catheter and seek fot the other ostium, to repeat the procedure in the other side.

Than we retrieve the catheter and the hysteroscope set used for cystoscopy and proceed to the surgery.

Results

Ten step tutorial technique, showing a less invasive, faster and cheaper than the usual cystoscopic with a guiding wired and pielographic catheter.

Conclusions

In ten steps this tutorial shows a fast, simple, low cost and reproducible technique for ureteral endoluminal painting using ICG to reduce operative time and avoid unnecessary dissections in surgeries.

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<https://esge.covr.be/cmdocumentmanagement/conferencemanager/documents/api/getdocument/14983/cmabstsms/0000216910/da163d609f9418ed3ad78c10604715054c8b7a49ba3c853e14849cb52afafa76>

The Role of Surgical Optimization in Improving Fertility Outcomes Among Infertile Women

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Background

Although the advancement of IVF has revolutionized reproductive medicine, minimally invasive fertility-optimizing surgeries continue to play a crucial role. Fibroids, particularly those originating from or disrupting the junctional zone, are thought to directly interfere with the implantation process. This hypothesis is supported by studies showing a decline in fertility as the size or number of leiomyomas increases. While evidence is limited, hysteroscopic myomectomy has demonstrated improved outcomes in infertile patients, with live birth rates ranging from 30-40% within the first year post-procedure. In contrast, while fertility societies lack sufficient data to fully endorse laparoscopic myomectomy for intramural fibroids, a recent study by Sinha et al. reported a 73% live birth rate following robotic-assisted laparoscopic myomectomy, with higher success rates in natural conception compared to assisted reproductive technologies. These findings emphasize the importance of myomectomy as a surgical optimization strategy prior to conception in infertile patients.

Methods

This case study describes the management of a 38-year-old woman with primary infertility, likely secondary to uterine fibroids. She had previously undergone abdominal myomectomy for abnormal uterine bleeding and infertility in her home country. Despite this, she continued to experience infertility and was referred to a fertility clinic. After failing timed intercourse (resulting in a chemical pregnancy) and intrauterine insemination with clomiphene, she underwent in-vitro fertilization (IVF), resulting in six euploid blastocysts, which were frozen as the patient sought a second opinion. Upon referral to our centre, further work-up revealed multiple type 3-6 intramural fibroids. The patient underwent robotic-assisted laparoscopic myomectomy and adhesiolysis. A subsequent saline infusion sonohysterogram (SIS) revealed a single posterior type 1 fibroid, prompting a second-look hysteroscopy with myomectomy. The patient then received intrauterine paediatric foley balloon placement and a uterine healing protocol to minimize the risk of intrauterine adhesions.

Results

Post-surgical follow-up with SIS and 3D ultrasound demonstrated a normal uterine cavity, with no recurrent fibroids or intrauterine synechiae. The patient attempted natural conception 3 months after surgery and achieved pregnancy. The pregnancy progressed without complications, and she delivered at 37 weeks via caesarean section, as recommended by Maternal-Foetal Medicine due to her history of multiple uterine surgeries.

Conclusions

Surgical optimization is crucial for improving fertility outcomes, particularly in patients with structural uterine abnormalities like fibroids. While ART remains an important option, surgical interventions offer a valuable approach to enhance both natural conception and ART success, underscoring their continued relevance in modern infertility management.

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"Complications after laparoscopic hysterectomy of the uterus. Solutions. A clinical case"

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Background

The total number of complications after TLH was observed in 10% of patients. Damage to the ureter - 2.0%, infections at the port site - 4.0%, infections of the arch - 4.0% of patients. (Mishra D, et al. Cureus. 2025)

The aim of this video is to show a non-standard way to deal with one of the most common complications of TLH using the video endoscopic method

Methods

Patient B, 64 years old. 18 days ago, surgery, TLH laparoscopy. Ultrasound examination: condition after extirpation of the uterus and appendages, hematoma of the vaginal stump up to 4-5 centimetres in size. Diagnostic laparoscopy was performed. Access to the pelvis is not visualized due to the pronounced adhesive process. The large omentum throughout the pelvis is tightly soldered by the parietal peritoneum. The presence of fibrin on the intestinal walls was noted. With the help of scissors, the adhesive processes were excised under visual control. Access to the small pelvis is provided. The sigmoid colon is connected by dense adhesions to the bottom of the wound, dissection of the formed adhesions is impossible due to the inflammatory oedema of the sigmoid wall. The tip of the vaginal stump is tightly fused with the wall of the sigmoid colon. The second stage of the operation using vaginal access has begun. The walls of the vagina are hyperaemic and swollen throughout. The suture of the stump is unstable, there is a divergence of the vaginal walls up to two centimetres. Under visual control, the formed cavity was emptied, from which up to 30.0 millilitres of fetid haemorrhagic-purulent discharge poured out. After sanitation of the formed cavity, the bottom of the wound, which is the sigmoid colon wall, was visualized. Under the control of a laparoscope, the area of treatment of the wound cavity, the integrity of the sigmoid colon wall was assessed, and no intestinal defects were visually detected. From the right corner of the vaginal wound, the passage into the abdominal cavity was photographed under the control of a laparoscope using a finger. A drainage tube with holes for flushing is installed through the right-side port to capture the abdominal cavity, the formed pelvic floor cavity and the vaginal cavity. 3 nodal ligatures were applied from the side of the vagina to match the walls of the vagina and ensure the normal operation of the installed drainage.

Results

Further management of the patient consisted in flushing the formed cavities three times within four days, after which the drainage was removed. In the postoperative period, antibiotic therapy and analgesic therapy were performed.

Conclusions

We propose the TLH complication elimination method shown in the video as the most convenient and easiest to perform for practicing surgeons.

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<https://esge.covr.be/cmdocumentmanagement/conferencemanager/documents/api/getdocument/14544/cmabstsms/0000211590/f5181b486948c51c0c139b2041ffdd94564d01148588d18c8d110c08e0072614>

Laparoscopic Management of Bilateral Hydropyosalpinges in an Adolescent with Delayed Diagnosis

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Background

This is a case of an 18-year-old patient with prolonged pelvic pain and elevated inflammatory markers, successfully managed through combined antibiotic therapy and laparoscopic intervention. The aim is to highlight the importance of timely, expert management and the key role of laparoscopy in both diagnosis and treatment.

Methods

An 18-year-old woman presented with one month of intermittent pelvic pain and fever (up to 38°C), without a definitive diagnosis or treatment during this period. Laboratory tests showed a markedly elevated CA-125 (850 U/mL). Imaging (ultrasound and MRI) identified bilateral hydropyosalpinges. Initial treatment included intravenous antibiotics (cefoxitin and metronidazole) and oral doxycycline for 4 days. Laparoscopy was then performed, beginning with thorough visualization of the pelvis. Dense adhesions involving the fallopian tubes and uterus were identified, as well as bilateral distended tubes consistent with hydropyosalpinges. Extensive adhesiolysis was carried out, followed by drainage of bilateral tubo-ovarian abscesses.

Results

The patient's CA-125 decreased from 850 to 450 following antibiotic therapy. Immediate postoperative levels dropped further to 350, and within one week to 50. The procedure was completed without complications. The patient recovered rapidly with resolution of symptoms and normalization of inflammatory markers.

Conclusions

This case underscores the importance of early, expert intervention in cases of pelvic inflammatory disease, particularly in young patients where fertility preservation is paramount. Despite a month-long delay in diagnosis and management, the coordinated use of targeted antibiotic therapy followed by timely laparoscopic surgery by an experienced team led to an excellent clinical outcome. Laparoscopy proved invaluable for accurate assessment, effective adhesiolysis, and definitive abscess drainage, highlighting its essential role in modern gynaecologic care.

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<https://esge.covr.be/cmdocumentmanagement/conferencemanager/documents/api/getdocument/14963/cmabstsms/0000192950/c56d55cb76835d93fd94c1158fb88f10ad8b69c44c263169089abc3e7896c0e4>

Minimally Invasive Management of Symptomatic Cesarean Scar Defect with Dense Pelvic Adhesions: A Case-Based Surgical Video

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Background

Isthmocele, a caesarean scar defect, is an increasingly recognized cause of abnormal uterine bleeding, particularly postmenstrual spotting. In patients unresponsive to medical therapy, surgical intervention may be required. We present the case of a symptomatic isthmocele in a woman with a history of two cesarean deliveries, managed successfully with laparoscopic repair.

Methods

A 45-year-old woman, gravida 2, parity 2 (both via caesarean section; last CS 10 years ago), presented with postmenstrual spotting lasting for approximately 10 days after menstruation. Endometrial biopsy performed due to persistent bleeding was reported as normal. A levonorgestrel-releasing intrauterine device had been previously placed at another centre but was removed due to lack of clinical benefit. Transvaginal ultrasound performed in our clinic revealed a 12×8 mm hypoechoic pouch at the site of the previous caesarean scar, consistent with isthmocele. Endometrial thickness was 4 mm, and the adnexa were unremarkable. A laparoscopic isthmocele repair was planned.

Results

During laparoscopy, dense adhesions involving the anterior abdominal wall and bladder were observed, consistent with the patient's history of previous caesarean deliveries. Adhesiolysis was performed to expose the uterine scar. The isthmocele pouch was identified, excised, and the defect was repaired using absorbable sutures. The procedure was completed laparoscopically without intraoperative complications.

Conclusions

Laparoscopic repair is an effective and safe option for symptomatic isthmocele in patients with prior caesarean sections. This case highlights the importance of considering isthmocele in the differential diagnosis of postmenstrual spotting and demonstrates that minimally invasive surgery can offer both diagnostic clarity and durable symptom relief, even in the presence of significant adhesions.

<https://player.vimeo.com/video/1089461356?autoplay=1>

Surgical Management of a Giant Ovarian Cyst in a 15-Year-Old: Mini-Laparotomy Technique with Fertility Preservation

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Background

Objectives: To describe the surgical management of a giant ovarian cyst in a 15-year-old patient using a mini-laparotomy technique, with an emphasis on fertility preservation.

Keywords: Fertility Preservation, Mucinous Cystadenoma, Adolescent Gynaecology, Mini-Laparotomy

Methods

Methods: Clinical data were retrieved from the hospital's electronic medical records system (S. Clínico). A video presentation was produced using intraoperative images, obtained with informed patient consent.

Results

Results: A 15-year-old female presented with progressive abdominal distension over the preceding eight weeks. Physical examination revealed a large abdominal mass extending above the umbilicus. Laboratory workup showed a negative beta-hCG and a mildly elevated CA 125 level of 51 U/mL. Abdominal ultrasound identified a unilocular cystic lesion with low-level echogenicity and a color score of 1, measuring 220 × 190 × 110 mm. The ADNEX model estimated a 99% probability of a benign tumour.

The patient consented to surgical intervention. A mini-laparotomy was performed via a lower abdominal incision. The cyst was accessed and punctured with a 5 mm trocar under controlled conditions to prevent spillage. A total of 2.2 litres of mucinous fluid were aspirated. The puncture site was subsequently sealed, and a cystectomy was carried out without difficulty. Upon inspection, the pelvic anatomy was preserved.

Conclusions

Conclusions: Cystectomy was successfully performed using a mini-laparotomy approach, allowing for complete excision of the cyst while preserving ovarian function. This case highlights the feasibility and benefits of a minimally invasive approach with fertility preservation in adolescent patients.

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The lost coil

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Background

To present a case of an embedded Mirena intrauterine device (IUD) following insertion during a caesarean section, highlighting the significance of accurate diagnostic imaging and thorough patient counselling. The case emphasizes the difficulties associated with managing embedded coils.

Methods

Case Description: We describe the management of a 34-year-old patient who underwent an elective caesarean section with concurrent Mirena IUD insertion in December 2022.

Results

The case involved initial care at a London hospital, followed by further consultations in Cyprus due to persistent symptoms, and subsequent management in the UK. Initial ultrasound scans failed to identify the misplacement of the coil. A hysteroscopy was inconclusive, failing to locate the coil. However, repeat ultrasound scans, including 3D imaging, successfully identified the coil embedded in the myometrium. Laparoscopic removal of the deeply embedded coil was performed, leading to symptom resolution and a positive postoperative outcome.

Conclusions

This case underscores the critical role of advanced diagnostic imaging, particularly ultrasound and 3D imaging, in locating intrauterine devices. The challenges of managing embedded coils are highlighted, as well as the importance of comprehensive patient counselling on potential complications during caesarean sections.

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Failure of unilateral sentinel lymph node mapping with methylene blue in endometrial adenocarcinoma

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Background

The purpose of this video is to demonstrate unilateral sentinel lymph node mapping failure associated with the use of methylene blue.

Methods

A 53-year-old patient presented with postmenopausal bleeding, and the endometrial biopsy revealed endometrial endometrioid adenocarcinoma. Image methods did not identify any abnormal findings other than the endometrial lesions. The patient is scheduled for a laparoscopic hysterectomy, bilateral salpingo-oophorectomy, and sentinel lymph node dissection. Consent for present and publication was obtained from the patient.

Results

This video demonstrates the dissection of lymph nodes in a patient with unilateral failure of mapping with methylene blue in a case of endometrial adenocarcinoma. Pathological examination revealed no metastatic lymph nodes on both sides of the pelvic region.

Conclusions

In conclusion, methylene blue may be associated with a higher risk of unsuccessful sentinel lymph node mapping.

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Comparative Analysis of Vaginal and Abdominal Uterine Manipulation in Laparoscopic Hysterectomy: The Boztosun Technique

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Background

Abstract: Background/Objectives: Laparoscopic hysterectomy is commonly performed for benign gynaecologic conditions, and the choice of uterine manipulation technique may influence surgical outcomes. The Boztosun technique, a modification of the classical Rein technique, enables intra-abdominal manipulation of the uterus without requiring transvaginal instruments. This study aimed to compare the Boztosun technique with a conventional vaginal uterine manipulator in terms of surgical efficiency and perioperative outcomes.

Methods

Methods: This retrospective study included 30 patients who underwent laparoscopic hysterectomy for benign indications at Akdeniz University Hospital between March 2022 and March 2024. Fifteen patients underwent surgery using the Boztosun technique, and fifteen with a vaginal uterine manipulator. Operative time, colpotomy time, manipulator placement time, hospital stay, uterine weight, haemoglobin change, and complications were compared.

Results

Results: The Boztosun technique was associated with significantly shorter operative time (81.67 ± 11.02 min vs. 109 ± 10.85 min, $p < 0.001$), colpotomy time (4.13 ± 0.92 min vs. 8.87 ± 0.92 min, $p < 0.001$), manipulator placement time (0.81 ± 0.27 min vs. 8.07 ± 1.22 min, $p < 0.001$), and hospital stay (2.13 ± 0.35 days vs. 3.53 ± 0.92 days, $p < 0.001$). No significant differences were found in uterine weight, haemoglobin decrease, or complication rates. All procedures were completed laparoscopically without conversion to open surgery.

Conclusions

Conclusions: The Boztosun technique may serve as a safe, efficient, and cost-effective alternative to vaginal uterine manipulators in laparoscopic hysterectomy. Its simplified intra-abdominal approach offers advantages in surgical workflow and recovery. Further prospective studies are needed to validate these findings and assess their applicability in broader clinical settings.

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More than Meets the Eye: Robotic-Assisted Laparoscopic Excision of Left-Sided Sacral and Pudendal Nerve Endometriosis

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Background

Aims

To demonstrate a robotic-assisted approach to the surgical management of complex endometriosis infiltrating the sacral nerve roots and pudendal nerve.

Background

Endometriosis affecting the sacral nerve roots and pudendal nerve is a rare but significant cause of neuropathic pain and voiding dysfunction. Surgical intervention aims to restore function while preserving vascular and neurological integrity. The involvement of branches of the internal iliac artery, proximity to the levator ani, and potential concomitant infiltration of the ureter or bowel necessitate a meticulous surgical approach.

Methods

Robotic-assisted laparoscopy was performed with neurolysis of the sacral nerve roots and pudendal nerves to facilitate safe excision of this large nodule.

Results

A 38-year-old woman presented with cyclical left-sided neuropathic pain, sensory deficits in the pudendal dermatome and voiding dysfunction. Imaging identified an endometriotic plaque affecting the left pelvic sidewall, associated with the sacral nerve roots (S2–4) and the levator ani. At initial pelvic survey, this nodule was only evidenced by a small indrawing of the peritoneum, but it was in fact infiltrating to a far greater extent caudally, posteriorly and laterally.

Conclusions

The robotic-assisted approach enables precise dissection in cases of complex pelvic endometriosis, allowing for nerve preservation and symptom relief. Multidisciplinary planning and careful intraoperative strategy are essential for optimising outcomes.

<https://player.vimeo.com/video/1089557615?autoplay=1>

Duplicated Ureter and Use of Indocyanine Green in a Robotic Platform to Prevent Postoperative Complications in Endometriosis

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Background

This is the case of a 45-year-old patient with chronic pelvic pain, dysmenorrhea, and dyschezia. We began by identifying the anatomical landmarks of the pelvis, focusing on the posterior compartment, to proceed with surgical treatment of endometriosis and ensure surgical damage control. During ureter identification, we observed ureteral duplication. In cases of uncertainty, it is essential to return to the promontory and trace the ureter's origin in the pelvis as it crosses the iliac vessels. In this case, we used only three 8 mm robotic arms: one for the camera, one for the monopolar scissors for tissue dissection, and another for the robotic bipolar grasper, with assistance from a 5 mm laparoscopic assistant port. The surgery then proceeded with complete treatment of posterior compartment endometriosis. We used indocyanine green and Firefly technology to assess ureteral perfusion after extensive dissection for disease removal. A hypovascularized area was identified on the ureteral wall. A double-J stent was placed to prevent late fistula formation and potential surgical complications.

Methods

One female patient with endometriosis

Results

Robotic surgery for endometriosis treatment

Surgery done in one time.

Conclusions

Use of technology can improve results and prevent future complications

<https://player.vimeo.com/video/1089561927?autoplay=1>

Going Sideways – Endometriosis Infiltrating the Lateral Wall of the Rectum

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Background

Aims

To demonstrate two cases where endometriosis was infiltrating the lateral wall of rectum in patients with sacral nerve root endometriosis.

Background

The majority of rectal bowel endometriosis infiltrates the anterior surface of the rectum. In the two cases highlighted, the nodule is retroperitoneal, arising from the sacral nerve roots and infiltrating into the lateral wall of the rectum. Nerve endometriosis is rare but can have debilitating symptoms and like rectal endometriosis is often associated with more severe/complex disease.

Methods

Robotic-assisted laparoscopy utilised in the surgical management of both cases.

Results

The first case highlights a forty-six-year-old having a hysterectomy and excision of endometriosis for pelvic pain. Preoperative imaging suggested deep endometriosis with superficial infiltration of the rectum with tethering to the left uterosacral ligament. During the procedure, this area infiltrated deeper/more lateral than expected and as the patient had not been previously counselled for bowel resection or neurolysis, a shave was performed without dissection of the sacral nerve roots. The second highlights a thirty-three-year-old with a known nodule infiltrating the sacral nerve roots, with associated symptoms including pain and incomplete bladder emptying, as well as imaging suggestive of rectal muscularis thickening. Robotic-assisted excision was performed with neurolysis of the sacral nerve roots and transanal disc resection of the rectal nodule.

Conclusions

Although most rectal nodules infiltrate the anterior surface of the bowel, clinicians should be mindful of unusual manifestations, especially those with an interest in neuropelvicology. The authors present two cases where the typical presentation of rectal wall endometriosis is not present.

<https://player.vimeo.com/video/1089562169?autoplay=1>

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Video in ePoster

Hysterectomy with Posterior Compartment Endometriosis: Standardization for teaching how to improve operative time

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Background

This surgery involves a patient with a condition refractory to clinical treatment and adenomyosis with endometriosis. We observe an involvement of the peritoneum by endometriosis in the posterior compartment and begin by identifying the critical pelvic structures. We open the peritoneum and perform ureterolysis and neurolysis using the robotic platform. In this case, we used only three 8 mm robotic arms: one for the camera, one for the monopolar scissors for tissue dissection, and another for the robotic bipolar grasper, with assistance from a 5 mm laparoscopic assistant port. The same surgical systematization is applied on the right side, and the excision of the diseased peritoneum is greatly facilitated by the use of robotic monopolar energy and the EndoWrist instrument. We then proceed to the excision of the posterior peritoneum in the retrocervical region. Next, we perform a hysterectomy with salpingectomy.

Methods

One female adolescent patient with endometriosis and adenomyosis

Results

Robotic surgery for endometriosis and adenomyosis treatment with a surgical systematisation that improves operative time for beginners.

Conclusions

Use of technology can improve good surgical results for fellows and beginner surgeons and prevent complications.

<https://player.vimeo.com/video/1089563216?autoplay=1>

No Need to Get Up - Robotic-assisted laparoscopic excision of endometriosis including transanal discoid excision and right nephroureterectomy without position change

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Background

Aims

To demonstrate the multidisciplinary surgical approach to the excision of severe and complex endometriosis, including a nephroureterectomy all via dorsal Lloyd-davis position.

Background

Complex presentations of endometriosis with infiltration of multiple pelvic compartments and structures require multidisciplinary care and surgery to be managed effectively and safely. Parametrial disease, causing obstructive uropathy is one of the more challenging presentations for endometriosis surgeons. The standard approach to nephroureterectomy is via a lateral decubitus position - this case, however, was managed entirely via a supine dorsal Lloyd-Davis position due to a significantly raised body mass index

Methods

Robotic-assisted laparoscopy was performed with excision of endometriosis, transanal discoid excision and right nephroureterectomy. The right kidney has essentially no normal cortex and appears cystic within its capsule. The surgical team adopted a structured and stepwise approach to the excision of all visible and palpable disease.

Results

The patient was a 29-year-old with symptoms of pelvic pain refractory to medical treatment. Preoperative imaging and assessment had revealed severe endometriosis infiltrating the rectum and parametria with complete loss of the right kidney due to obstructive uropathy. Functional urinary tract imaging showed a non-functioning right kidney. A significant factor in preoperative planning was the patient's raised BMI of 41.4. This made intraoperative repositioning and airway management a challenge which the surgical team sought to address by planning to avoid position change, unless necessary, during the procedure.

Conclusions

Complex endometriosis necessitates comprehensive patient centred care. Thorough preoperative assessment and discussion is essential to facilitate safe surgical management.

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Laparoscopic Management of an Ovarian Endometrioma with Bilateral Ureteric Endometriosis: Video Demonstration of TLH-BSO and Ureterolysis

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Background

To illustrate step-wise laparoscopic total hysterectomy with bilateral salpingo-oophorectomy and bilateral ureterolysis for a synchronous right ureter-adherent 7 cm ovarian endometrioma and contralateral peri-ureteric endometriotic implant.

Methods

A 53-year-old gravida 2 para 2 woman presented with chronic pelvic pain, a multilocular right adnexal mass, and elevated tumor markers (CA-125: 109 U/mL, CA 19-9: 42 U/mL). A four-port transperitoneal laparoscopy was performed. Initial steps included adhesiolysis between the sigmoid colon and the left lateral pelvic wall. The round ligaments were sequentially coagulated and transected to facilitate retroperitoneal access and visualization of both ureters. The infundibulopelvic ligaments were coagulated and divided. Adhesions between the left ovary, bowel, and uterus were sharply dissected using cold scissors. Bilateral ureterolysis was conducted proximally to distally using bipolar energy and scissors with attention to ureteric safety through transillumination and angled visualization. The right adnexal mass and ovary were excised en bloc following adhesiolysis. Anterior dissection between bladder and uterus was achieved via a lateral approach. A left-sided endometriotic nodule overlying the ureter was excised following vascular skeletonization and occlusion of uterine and obliterated umbilical arteries using metal clips. Uterus and adnexa were removed vaginally following colpotomy, and the vaginal cuff was repaired in two layers.

Results

Operating time totalled 148 minutes with estimated blood loss of 100 mL. There were no intra-operative complications, and bilateral ureteric peristalsis was preserved. The patient tolerated oral intake six hours post-operatively, ambulated at eight hours, and was discharged on postoperative day one. Histopathology confirmed right ovarian endometrioma and superficial peri-ureteric endometriosis with negative margins. At six-month review she was pain-free and fully active.

Conclusions

Ureteric involvement by endometriosis transforms routine adnexal surgery into a high-risk procedure, particularly when a sizeable complex adnexal mass accompanies. Advanced retroperitoneal dissection techniques and ureterolysis are essential for optimal outcomes in complex gynaecologic surgery which requires experienced hands.

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Technique of Vaginal Assisted Laparoscopic Radical Trachelectomy for cervical cancer patient with a history of subtotal hysterectomy for placenta percreta

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Background

Laparoscopic surgery is still an option in cervical cancer patients when a number of preventive measures are performed in selected cases. However, application of minimal invasive surgery becomes challenging in patients with altered pelvic anatomy due to previous surgeries, such as subtotal hysterectomy for placenta percreta. In this report, we present a case of vaginal-assisted laparoscopic radical trachelectomy (VALRT) in a cervical cancer patient with a history of subtotal hysterectomy and previous bladder injury, highlighting key technical steps and oncologic considerations.

Methods

A 31-year-old multiparous woman presented with persistent vaginal spotting. She had a history of two caesarean deliveries, and during her second delivery, three years ago, she underwent a subtotal hysterectomy for placenta percreta, complicated by intraoperative bladder perforation. Vaginal examination revealed a 3 × 1 cm polypoid mass at the cervical stump. Histopathological evaluation of the polyp demonstrated undifferentiated carcinoma of cervical origin.

Pelvic MRI and PET-CT showed no evidence of extrauterine or residual disease. LEEP and endocervical curettage confirmed the absence of residual tumour. The case was evaluated in multidisciplinary tumour board, and vaginal-assisted laparoscopic radical trachelectomy with bilateral pelvic lymphadenectomy and bilateral salpingo-oophorectomy was planned.

A prophylactic double-J ureteral stent was inserted preoperatively. The laparoscopic procedure was performed without the use of a uterine manipulator. A vaginal manchette was created to prevent tumour spillage during colpotomy. Radical excision of the cervical stump, pelvic lymph node dissection, and salpingo-oophorectomy were completed laparoscopically.

Results

The total operation time was 330 minutes, and the estimated blood loss was 10 cc. The patient had an uneventful recovery and was discharged on the second postoperative day. Final pathology revealed no residual tumour in the trachelectomy specimen, and all dissected pelvic lymph nodes showed only reactive changes without evidence of metastasis. Adjuvant concurrent chemoradiotherapy was initiated during the first postoperative week. At 12-month follow-up, the patient developed pulmonary metastases and was subsequently treated with systemic chemotherapy. As of the most recent evaluation, the disease remains stable under systemic treatment.

Conclusions

Laparoscopic is a feasible and oncologically appropriate option in selected cervical cancer patients with complex surgical histories, such as prior subtotal hysterectomy for placenta percreta. Strict adherence to oncologic principles—including omission of intrauterine manipulators, avoidance of tumour manipulation, and use of a protective vaginal manchette—are essential to ensure safety and efficacy. Minimally invasive surgery can still play a role in challenging cases when applied with proper surgical technique and multidisciplinary planning.

<https://player.vimeo.com/video/1089662987?autoplay=1>

Nerve sparing multivisceral resection for deep infiltrating endometriosis in a virgin patient without intrauterine manipulator

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Background

Step by step demonstration laparoscopic to nerve-sparing multivisceral resection for deep infiltrating endometriosis involving bladder visceral serosa, left IP ligament, vagina, rectosigmoid colon, appendix and both sacrouterine ligament in a virgin patient without use of intrauterine manipulator.

Methods

A 24-year-old nulliparous virgin woman presented with severe dysmenorrhea (9/10), dyschezia (9/10), and constipation, all resistant to medical treatment. Pelvic MRI revealed bilateral sacrouterine ligament involvement, a 5 cm endometrioma on the left ovary, a 3 cm nodule in the rectosigmoid colon (12 cm from anal verge), a 3 cm vaginal nodule, and additional involvement of the left infundibulopelvic ligament, bladder serosa, and appendix. A laparoscopic multivisceral, nerve-sparing resection of endometriotic lesions along with segmental bowel resection planned.

Results

Intraoperatively, a 5 × 4 cm in bladder serosa involved by endometriosis was identified, with complete obliteration of the pouch of Douglas and a distinct nodule on the rectosigmoid colon. The left ovary, containing an endometriotic cyst, was adherent to the left pelvic sidewall. It was mobilized and suspended to the abdominal wall using 1-0 sutures.

The left pararectal space was dissected and ureterolysis was performed up to the ureteric tunnel. The right pararectal space was also developed. A nodule was observed on the posterior vaginal wall. Following opening of the vaginal wall, a 2 × 3 cm vaginal nodule was identified and excised after complete dissection of the rectovaginal space. A partial vaginectomy was then performed.

Bilateral sacrouterine ligament nodules and a 3 cm nodule on the left infundibulopelvic ligament were excised. As the distal portion of the appendix was involved with endometriosis, appendectomy was performed. A 4 cm nodule overlying the rectosigmoid colon necessitated segmental bowel resection. The inferior hypogastric plexus and pelvic splanchnic nerves were visualized and successfully preserved on both sides.

After freeing the rectum from its attachments, the resection line was determined, and a laparoscopic segmental bowel resection was performed using a stapling device. Via a mini-laparotomy, the proximal colon was resected, the anvil was introduced, and end-to-end anastomosis was completed laparoscopically. A pelvic drain was inserted at the end of the procedure.

The total operative time was 250 minutes, with an estimated blood loss of 50 cc. The patient was discharged on postoperative day four. At 13-month follow-up, the patient remained completely symptom-free, reporting no dysmenorrhea (0/10), dyschezia, or constipation.

Conclusions

This case illustrates that omission of an intrauterine manipulator in virgin patients does not hinder the surgical management of DIE. Uterine manipulation can be safely achieved intraabdominally by the assistant. Laparoscopic multivisceral and nerve-sparing resection is feasible and effective even in anatomically challenging scenarios, offering symptom resolution and preservation of pelvic nerve integrity.

<https://player.vimeo.com/video/1089679804?autoplay=1>

Technique of laparoscopic paraaortic lymphadenectomy and ovarian transposition in a complex scenario of bulky lymph nodes for locally advanced cervical cancer

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Background

Surgical staging through paraaortic lymphadenectomy is a crucial step in the management of locally advanced cervical cancer, particularly for tailoring the radiation field. It is well established that metastatic lymph nodes can be missed in nearly 30% of patients undergoing PET-CT alone—patients who would otherwise be upstaged with surgical staging. Furthermore, several studies have shown that surgical staging improves progression-free survival, especially in patients with stage IIB disease.

Methods

In this video presentation, we demonstrate a step-by-step approach to laparoscopic paraaortic lymphadenectomy and ovarian transposition in a patient with locally advanced cervical cancer and bulky paraaortic lymph nodes.

Results

The patient was a 31-year-old woman presenting with a 6 cm bulky cervical tumor. Pelvic MRI revealed enlarged pelvic lymph nodes. The clinical stage was FIGO IIIC1 (radiologic). After multidisciplinary tumour board discussion, laparoscopic paraaortic staging with bilateral ovarian transposition was recommended.

The procedure included laparoscopic paraaortic lymphadenectomy, bilateral ovarian transposition, and resection of a bulky right pelvic lymph node. The total operation time was 185 minutes, with an estimated blood loss of 50 cc. There were no intraoperative or postoperative complications. The patient was discharged on postoperative day two.

Final pathology revealed 4 out of 12 paraaortic lymph nodes to be metastatic. The patient was subsequently referred for extended-field chemoradiotherapy.

Conclusions

Laparoscopic paraaortic staging plays an essential role in the treatment of locally advanced cervical cancer. Its advantages include accurate identification of metastatic paraaortic disease, the option of ovarian preservation through transposition in young patients, and no delay in initiating definitive radiotherapy.

<https://player.vimeo.com/video/1089696706?autoplay=1>

Tips and tricks for hysteroscopic resection of a large type I fibroid: A Video Presentation

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Background

A step-by-step approach for hysteroscopic myomectomy in patients with submucosal fibroids, focusing on key surgical techniques that enhance safety, preserve uterine integrity, and ensure complete fibroid removal.

Methods

We present a case of a 49-year-old woman with heavy menstrual bleeding and a type I submucosal fibroid measuring 32 × 23 × 20 mm. The procedure was performed using a 27 Fr bipolar resectoscope under general anaesthesia. Intraoperative strategies emphasized include: minimal cervical dilation to reduce fluid leakage, continuous saline infusion with controlled suction for optimal visibility, avoidance of repeated scope removal to maintain intrauterine pressure and identification of myometrial margins to ensure complete resection and prevent perforation, particularly in patients with prior caesarean sections.

Written informed consent was obtained from the patient for the procedure and for the use of anonymized video material for educational purposes.

Results

The fibroid was completely resected with a total fluid deficit of 400 mL, well within safe limits. The patient recovered uneventfully and was discharged the same day with minimal postoperative bleeding.

Conclusions

This video highlights essential surgical techniques and intraoperative considerations for performing safe and effective hysteroscopic myomectomy. Attention to fluid management, visualization, and preservation of cervical and uterine integrity is critical for optimal outcomes, especially in women with prior uterine surgery or fertility concerns.

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Efficient and Accessible: Scissor-Based Endometrial Polyp Resection for All Settings

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Background

Hysteroscopic morcellators may be limited by cost, accessibility, and anatomical constraints. Hysteroscopic scissors offer a low-cost, effective alternative suitable for diverse clinical settings, including outpatient clinics and low-resource environments. Our aim is to demonstrate the efficacy, accessibility, and versatility of hysteroscopic scissors for the resection of endometrial polyps.

Methods

This video abstract presents multiple representative cases in which endometrial polyps were removed using hysteroscopic scissors. All procedures were performed in an outpatient setting, without mechanical morcellation. The cases include polyps located at the lateral uterine wall, fundus, cervical canal near the internal os and near the tubal ostia. Surgical video is used to illustrate visualization, accessibility, technique, and the tactile precision required for scissor-based polypectomy.

Results

In each case, the polyps were successfully excised using hysteroscopic scissors, followed by removal with graspers or spontaneous expulsion through distention flow. Lateral wall polyps were readily accessible and fully resected. Fundal polyps and near the tubal ostia polyps, often difficult to reach their pedicles with morcellator, were effectively managed with hysteroscopic scissors. Specimens were retrieved intact, with histologic evaluation benefiting from the absence of cautery or fragmentation. No intraoperative complications were encountered. The technique requires some expertise, which can easily be acquired.

Conclusions

Scissor-based hysteroscopic polypectomy is a practical and cost-effective alternative to morcellation. It eliminates reliance on disposable equipment, maintains histologic integrity, and can be performed in diverse environments, including outpatient clinics and resource-limited settings. The approach also supports hysteroscopic skill development in trainees and early-career surgeons. Broader implementation of this technique may enhance global access to minimally invasive intrauterine procedures and promote equitable care in gynaecology.

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Undiagnosed Subseptate Uterus and Repeated Implantation Failure

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Background

Subseptate uteri are often underdiagnosed due to limitations in conventional imaging, particularly when anomalies are subtle or misclassified as arcuate variants. These overlooked defects can significantly impair implantation, even in patients undergoing IVF with euploid embryos, contributing to recurrent implantation failure (RIF) despite optimal embryo quality. To evaluate the diagnostic limitations of imaging modalities in detecting subseptate uterus or residual uterine septa and to highlight the clinical impact of hysteroscopic resection on reproductive outcomes in patients with RIF.

Methods

This is a retrospective case series of four patients with RIF despite appropriate fertility treatment, including in vitro fertilization and transfer of euploid blastocysts. All patients underwent transvaginal 3D ultrasound (TV 3D US) with/without saline infusion sonohysterogram imaging—3D ultrasound, saline infusion sonohysterography (SIS), which either failed to identify or underestimated the extent of uterine septa. Each patient subsequently underwent diagnostic hysteroscopy which confirmed the presence of subseptate uterus in 3 patients and significant residual septum in one patient. Hysteroscopic septoplasty was performed using scissors or resectoscope loop with monopolar current. Pre- and post-operative imaging and clinical outcomes were reviewed.

Results

All patients had multiple failed euploid frozen embryo transfers and one patient had a history of recurrent pregnancy loss. Hysteroscopic septoplasty was performed successfully in each case. There were no intraoperative or postoperative complications. In all patients, postoperative TV 3D US with SIS studies were normal. All patients conceived during the first frozen-thawed cycle after surgery. One patient delivered and three patients have ongoing pregnancies.

Conclusions

Subseptate uterus remains an underdiagnosed contributor to unexplained RIF. Standard imaging may fail to detect or misclassify these anomalies, delaying appropriate treatment. Hysteroscopy is both diagnostic and therapeutic and should be considered in patients with repeated RIF. Timely recognition and surgical correction of subseptate uterus may restore endometrial receptivity and optimize reproductive success.

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MRI Shortcomings in Diagnosing Uterine Septa: Case Series and Surgical Correlation

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Background

Magnetic resonance imaging (MRI) is frequently used to evaluate uterine anomalies, yet it often lacks the sensitivity to differentiate septate, bicornuate, and didelphys uteri accurately. Misclassification can delay diagnosis and appropriate surgical management, with significant implications for reproductive outcomes. Our aim is to demonstrate MRI shortcomings in distinguishing between septate, bicornuate and didelphys uteri.

Methods

We present a case series of four patients with history of reproductive failure, who were found to have uterine anomalies on MRI. Each patient underwent additional evaluation with 3D transvaginal ultrasound (TV 3D US) with/without saline infusion sonohysterogram (SIS) and subsequent diagnostic hysteroscopy and laparoscopy. Imaging findings were compared with intraoperative assessments to evaluate concordance and assess impact on clinical management. Septoplasty was performed in all patients.

Results

In all four cases, MRI incorrectly classified the uterine anatomy. Two patients were diagnosed with the bicornuate uterus, and two with a uterus didelphys. However, TV 3D US with/without SIS and surgical findings revealed significant subseptate in one patient, combined partial bicornuate and septate uterus in one patient and septate uterus reaching the external cervical os in two patients. Surgical videos and pre and post operative TV 3D US with SIS are demonstrated in 2 patients. Reproductive history before and after septoplasty is discussed.

Conclusions

MRI, though commonly used for evaluating Müllerian anomalies, has limited sensitivity for accurate classification. When imaging is discordant or inconclusive, direct visualization through hysteroscopy and laparoscopy is essential. Surgical confirmation ensures accurate diagnosis, guides treatment decisions, and informs reproductive counselling—especially in patients with infertility, pregnancy loss, or prior obstetric complications.

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Laparoscopic Hysterectomy Combined with TVT Procedure Under Direct Visualization: A Single-Session Approach

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Background

The coexistence of abnormal uterine bleeding and stress urinary incontinence is common in peri- and postmenopausal women. Combining gynaecologic and urogynaecology procedures in a single session may improve surgical efficiency and patient outcomes. However, blind passage of TVT (tension-free vaginal tape) needles can carry the risk of bladder or ureteral injury, particularly in patients with altered pelvic anatomy. Laparoscopic assistance during TVT placement offers the advantage of direct anatomical visualization, enhancing the safety and precision of the procedure.

Methods

48-year-old multiparous woman with a history of prior caesarean deliveries presented with abnormal uterine bleeding and stress-predominant mixed urinary incontinence. Total laparoscopic hysterectomy and bilateral salpingectomy were performed without complication. Prior to TVT needle insertion, cystoscopy was carried out to assess bladder anatomy, identify ureteral orifices, and rule out a duplicated collecting system. The Retzius space was accessed laparoscopically through the anterior peritoneum. TVT needles were passed under direct visualization, ensuring safe trajectory along the posterior pubic bone. The mesh was placed tension-free and secured suburethrally.

Results

The procedure was completed successfully without intraoperative or postoperative complications. The TVT tape was accurately positioned under laparoscopic guidance, with no evidence of bladder or urethral injury on post-placement cystoscopy. The anterior peritoneum was reapproximated following haemostasis. The patient had an uneventful recovery and was discharged in stable condition. Early follow-up showed resolution of urinary incontinence and no surgical morbidity.

Conclusions

Laparoscopic-assisted TVT placement during the same session as hysterectomy is a feasible and safe approach in selected patients. Direct visualization of pelvic structures enhances procedural precision and reduces the risk of organ injury. Combining gynaecologic and urogynaecology procedures may improve surgical efficiency, minimize anaesthesia exposure, and optimize patient outcomes.

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Diagnosis and treatment of concurrent transverse vaginal septum and complete uterine septum : a rare case report

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Background

A transverse vaginal septum is a rare anomaly of the female reproductive system, and its coexistence with a complete uterine septum is an exceptionally uncommon finding. The condition develops due to incomplete resorption following the fusion of the Müllerian ducts with the urogenital sinus. In cases of complete vaginal septum, menstrual blood accumulates behind the obstruction, leading to hematocolpos, hematometra, and cyclical abdominopelvic pain, whereas partial septa more commonly present with symptoms such as dyspareunia and dysmenorrhea. Here we present the diagnosis and treatment of concurrent transverse vaginal septum and complete uterine septum in a patient, who presented to seek assistance for conception.

Methods

Our patient is 23 years old female and married for 2 years. She was referred to our clinic due to dyspareunia and difficulty conceiving. Physical examination revealed normally developed secondary sexual characteristics. A 3–4 cm blind-ending vaginal canal was observed, with menstrual blood emerging from a pinpoint opening at the 1 o'clock position. Ultrasonography revealed fluid collection between the vaginal septum and cervix, along with a complete uterine septum extending from the cervix to the uterine fundus. Additionally, a 10 mm polyp was identified in the left hemicavity. Both ovaries and paraovarian areas appeared normal. Surgical treatment was initiated with an incision at the septal ostium, creating a vaginal opening and restoring patency. Once the cervix was reached, the uterine septum was resected using a resectoscope, and the polyp was removed. To prevent postoperative adhesions, hyaluronic acid gel was applied to the uterine cavity. A detailed description of the diagnosis and surgical procedure is presented in the video.

Results

The total operative time was 50 minutes. No early postoperative complications were observed. At the one-month follow-up, the vagina appeared to have a normal width, and a single uterine cavity was visualized.

Conclusions

The diagnosis of concurrent transverse vaginal septum and complete uterine septum requires careful evaluation. Hysteroscopy offers an effective and minimally invasive alternative to conventional treatment approaches.

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Laparoscopic Myomectomy with Endobag-Assisted Morcellation for Large Intramural Subserosal Fibroid: A Case Report

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Background

Laparoscopic myomectomy is a minimally invasive alternative to laparotomy for the treatment of symptomatic uterine fibroids, particularly in women seeking fertility preservation. However, fibroids larger than 10–12 cm are generally considered challenging due to technical limitations and the risk of intraoperative complications. Recent guidelines advocate the use of contained morcellation systems to reduce the risk of tissue dissemination during power morcellation. This case highlights the successful laparoscopic management of a large intramural subserosal fibroid using an endobag-assisted morcellation technique in a 34-year-old single woman with no history of sexual intercourse.

Methods

A 34-year-old single nulligravid woman presented with complaints of menorrhagia. Her hemoglobin level had decreased from 13 g/dL to 10 g/dL over the past 20 days. Transvaginal ultrasonography revealed an approximately 10 cm intramural subserosal fibroid located at the uterine fundus. A laparoscopic myomectomy was planned to use a power morcellator and endobag. Following standard trocar placement, intraoperative exploration identified a 12 cm fibroid. A vertical myometrial incision was made using monopolar cautery, and the fibroid was enucleated using a combination of sharp and blunt dissection with the assistance of a dissector device. Deep uterine defects were repaired obliquely with synthetic 0 V-Loc sutures. An endobag was placed, and the fibroid was secured inside. Power morcellation was performed under direct visualization within the endobag, minimizing the risk of tissue dissemination and preventing spillage.

Results

The total operative time was approximately 4 hours with an estimated blood loss of 400 mL. No intraoperative complications occurred. Postoperatively, the patient developed minimal subcutaneous emphysema, likely due to prolonged operative time, which resolved spontaneously. She was mobilized within 6 hours and discharged on postoperative day 1. At 2-month follow-up, the patient reported a significant reduction in menstrual bleeding.

Conclusions

This case demonstrates that laparoscopic myomectomy can be safely and effectively performed by experienced surgeons even for large (<13 cm) intramural subserosal fibroids. Controlled morcellation using an endobag is a valuable tool for minimizing the risk of tissue dissemination, especially in light of FDA guidelines. Laparoscopic management offers advantages such as less adhesion formation, faster recovery, and preservation of fertility potential. Surgeons should be trained in advanced laparoscopic techniques to meet the demands of large fibroid cases. Adhering to fundamental surgical principles and thorough preoperative planning reduces complications and improves patient outcomes.

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Video in ePoster

A Case of Isolated Bladder Endometriosis as a Possible Caesarean Section Complication

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Background

A Case of Isolated Bladder Endometriosis as a Possible Caesarean Section Complication

Methods

Results

Conclusions

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Tubo-Ovarian Abscess: Dilemma Between Pelvic Inflammatory Disease and Appendiceal Perforation

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Background

To illustrate a case in which the presence of a copper coil raised strong suspicion of Pelvic Inflammatory Disease (PID), but a perforated appendix was ultimately identified as the primary cause of the tubo-ovarian abscess (TOA).

We report the case of a 34-year-old nulliparous female patient presenting with persistent lower abdominal pain, nausea, and vomiting.

Methods

A transvaginal ultrasound identified a large multiloculated right adnexal mass consistent with TOA, confirmed through CT imaging, which also revealed involvement of the caecal pole and small bowel obstruction. Following elevated inflammatory markers and a negative urinalysis, surgical intervention was deemed necessary due to clinical deterioration.

Pre-operative planning included a multidisciplinary team (MDT) discussion involving gynaecological and surgical specialists. The operation was performed collaboratively.

Initial laparoscopy uncovered inflammatory pelvic phlegmon involving the small bowel, right fallopian tube, and ovary, alongside a right ovarian cyst and a normal left adnexa. Given the findings, a midline laparotomy was performed. Mobilization of the small bowel revealed an inflamed terminal section adherent to the abscess, requiring adhesiolysis. During pelvic dissection, a severely inflamed appendix was identified, leading to a right ovarian cystectomy and appendectomy with Ligasure, followed by suturing the base with 3-0 PDS. A partial omentectomy was also conducted, with a 20 French Robinson drain placed in the pelvis for postoperative drainage.

Results

Histology confirmed a perforated appendix, an inflamed corpus luteum, and changes in the omental tissue, with no atypia or malignancy. Vaginal and cervical swabs showed no growth. Two months post-surgery, imaging revealed no adnexal mass, normal ovaries, and no free fluid.

Conclusions

Accurate identification of the infection source in TOA is essential for timely diagnosis and management. Distinguishing between gynaecological and gastrointestinal origins influences antimicrobial therapy and surgical decisions, ultimately impacting patient outcomes.

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Shave, Don't Slice: Robotic Management of Anterior DIE with Mucosal Integrity

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Background

To illustrate the role of bladder nodule shaving with mucosal preservation in the surgical management of suspected deep infiltrating endometriosis (DIE) in a patient with anterior compartment disease, as part of a multidisciplinary robotic approach.

Methods

A 47-year-old nulliparous woman presented with severe dysmenorrhea, dyspareunia, and dyschezia. She had minimal urinary symptoms. CA-125 was elevated (41 U/mL). Ultrasound showed adenomyosis. MRI revealed a lesion anterior to the uterus abutting the bladder, with normal ureters and bowel. Cystoscopy was normal. After multidisciplinary discussion, a joint robotic procedure was performed: total Robotic hysterectomy (TRH), bilateral salpingo-oophorectomy (BSO), bilateral ureterolysis, adhesiolysis, rectovaginal nodule excision, and shaving of a bladder nodule with preservation of mucosa and reinforcement of the detrusor layer. Intraoperatively, the uterovesical fold was obliterated by endometriosis. The left adnexa were adherent and encasing the left ureter. The bladder nodule was shaved from the detrusor without entering the mucosa. Cystoscopy and sigmoidoscopy confirmed mucosal integrity. The patient recovered uneventfully and voided spontaneously postoperatively.

Results

Bladder shaving offers a safe and effective alternative to partial cystectomy in selected cases where complete excision can be achieved without mucosal involvement.

Conclusions

Compared to partial cystectomy, bladder shave reduces the risk of complications such as vesicovaginal fistula and the need for prolonged catheterisation. Studies consistently show excellent outcomes with bladder shaving, including symptom relief and low recurrence rates. When performed by experienced teams within a multidisciplinary setting, conservative approaches like bladder shaving can achieve radical excision while minimizing morbidity.

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Vaginal cold knife morcellation technique of a large fibroid uterus after a Robot-assisted Total Hysterectomy

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Background

Uterine size is one of the determining factors on the feasibility of the minimal access approach. This is because morcellation of a large fibroid uterus after minimal access surgery remains a challenge. There are currently no standardised procedures available to date.

Methods

The aim was to demonstrate the vaginal in-bag cold knife morcellation technique is a simple and reproducible method of sectioning and vaginal retrieval of the bulky uterus.

Results

We present our standardised approach to vaginal in-bag morcellation of a large fibroid uterus. The da Vinci Xi Surgical System (Intuitive Surgical, Sunnyvale CA) was used to perform the total hysterectomy. The Alexis Contained Extraction System was used vaginally to morcellate the uterus using a scalpel under direct vision. The use of the guard protected the bag from sharp instrumentation during the morcellation of the uterus. The uterine size of the patient in the video selected demonstrates a 300g fibroid uterus in a virgo intact patient. The morcellation operative time was 7.3 minutes. The procedure was completed successfully without any complications.

Conclusions

The vaginal in-bag cold knife morcellation technique after a total robotic hysterectomy is a feasible, simple, and reproducible method of bulky uterus morcellation through the vaginal orifice.

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The Mirage of Myomas: Laparoscopic Management of a Degenerating Broad Ligament Fibroid with Pelvic Endometriosis

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Background

Laparoscopic myomectomy for large fibroids involving the broad ligament is surgically demanding due to distorted pelvic anatomy and proximity to vital structures such as the ureter, bladder, and uterine vessels. While subserosal fibroids are often amenable to minimally invasive excision, broad ligament extension increases complexity. This case highlights the safe laparoscopic removal of a soft, degenerating fibroid measuring approximately 8 cm, with concurrent excision of superficial endometriosis involving the left uterosacral ligament and pararectal space. The procedure exemplifies the feasibility of advanced laparoscopic techniques in complex myomectomy cases with proper anatomical orientation and surgical planning.

Methods

Case Presentation

A 34-year-old woman presented with chronic menorrhagia and was initially diagnosed with a large subserosal fibroid during her pregnancy in 2022, for which she delivered by caesarean section. Postpartum, her symptoms persisted. Imaging revealed a degenerating fibroid with extension into the broad ligament, along with signs of pelvic endometriosis. Given her symptoms and the desire for uterine preservation, laparoscopic myomectomy and excision of endometriosis were planned.

Results

Key Surgical Steps

Laparoscopic access was achieved using a closed technique, with four ports placed under direct vision. Pelvic survey revealed a degenerating fibroid distorting the broad ligament and superficial endometriotic lesions. Ureterolysis was performed meticulously on the left side to safely mobilize the ureter from the operative field. Vasopressin was injected into the fibroid capsule for haemostasis. A vertical myometrial incision was made anteriorly, and the fibroid was enucleated using a myoma screw, with piecemeal dissection due to degeneration. It was retrieved in a tissue containment bag via a slightly extended umbilical port. The uterus was reconstructed in layers using barbed and conventional sutures. Endometriotic foci were excised, cavity integrity confirmed with dye, and a drain was left in situ.

Conclusions

This case demonstrates that laparoscopic myomectomy for large broad ligament fibroids is both feasible and safe when performed with meticulous surgical technique and thorough understanding of pelvic anatomy. Concurrent excision of endometriotic lesions can be effectively integrated into the procedure, ensuring comprehensive symptom management while preserving uterine function.

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Asymmetric Subseptate Uterus in Patients with Recurrent Pregnancy Loss: Diagnosis and Management

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Background

To demonstrate the role of hysteroscopy in identifying and correcting asymmetric subseptate uterus in patients with recurrent pregnancy loss (RPL)

Methods

This video shows three cases of asymmetric subseptate uteri. The patients presented with history of unexplained RPL. The first case involves a patient whose hysteroscopy at another facility was reported as normal; however, transvaginal 3D ultrasound (TV 3D US) and a repeat hysteroscopy at our centre confirmed the diagnosis. Hysteroscopic septoplasty was performed at the same session. The second case illustrates a morphological variant with a markedly flat apex and asymmetric subseptate uterus. The third case highlights the technical difficulty of diagnosing an asymmetric subseptate uterus under low intrauterine distension, which initially obscured visualisation of the anomaly. In all cases, hysteroscopic scissors were used for cavity mapping and stepwise septum division, followed by bipolar energy for coagulation and haemostasis.

Results

Asymmetric cavity architecture was confirmed in each patient despite prior imaging and hysteroscopic evaluations that failed to identify the subseptate anomaly. Hysteroscopic septoplasty effectively restored a symmetrical cavity. Minimal bleeding was observed and controlled with bipolar coagulation. Postoperative TV 3D US confirmed normalized cavity contours. One patient conceived spontaneously following the procedure, while the other two patients are currently trying to conceive.

Conclusions

Asymmetric subseptate uterus is a frequently overlooked uterine anomaly that can lead to RPL. Hysteroscopy is essential for accurate diagnosis and safe surgical correction.

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Septate Uterus Variants: Diagnostic and Management Challenges Related to Tissue Composition and Vascularity

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Background

To present a case series demonstrating the variability of septate uteri; including vascular, avascular, and combined types and to highlight the management challenges related to differences in septal vascularity.

Methods

Surgical videos of hysteroscopic septoplasty in four patients with septate uteri. Two cases involved vascular septa characterized by pinkish, well-vascularized tissue, while one case involved an avascular, dense fibrous septum. The fourth case was a combined fibrous and vascular septum. Surgical resection was performed using hysteroscopic scissors and/or resectoscope loop. In vascular septa, careful technique and energy modulation were necessary to control bleeding, whereas the avascular septum allowed for smoother dissection with minimal bleeding. The combined septum required intraoperative adaptation of the surgical approach.

Results

Vascular septa demonstrated increased bleeding risk and required meticulous intraoperative management. The avascular septum's dense fibrous tissue presented less bleeding but more resistance during resection. The combined septum case highlighted the dynamic nature of septal composition and the need for real-time surgical decision-making. These differences underscore the importance of preoperative recognition of tissue characteristics to ensure optimal outcomes.

Conclusions

Complete uterine septa vary significantly in their tissue composition, particularly in vascularity, which impacts surgical risk and management. Identifying whether a septum is vascular or avascular prior to surgery—potentially through targeted imaging—can help minimise intraoperative complications and allow for more tailored surgical planning. Awareness of these anatomical variations is essential to improving patient safety and reproductive outcomes.

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A follow-up hysteroscopic evaluation is necessary after surgery for uterine fibroids, particularly following hysteroscopic procedures.

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Background

Various complications can occur with hysteroscopic surgery. However, there are few reports concerning 'endometrial defects' or 'delayed healing of the endometrial wound.'

Methods

I report on the healing process of the uterine cavity following myomectomy, including our own clinical cases.

Results

Following surgical procedures on the uterus, changes or effects on the uterine cavity may occur. Second-look hysteroscopy is indicated when fertility preservation is desired, when the patient hopes to conceive, or when symptoms do not improve after surgery for multiple uterine fibroids.

Conclusions

Second-look hysteroscopy is recommended in all cases after hysteroscopic surgery for submucosal fibroids, endometrial polyps, or intrauterine adhesions in patients wishing to conceive. Pregnancy should be allowed only after confirming intrauterine healing by hysteroscopic evaluation.

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Balancing Surgery and Assisted Reproduction: Fertility Optimization in Stage IV Endometriosis

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Background

Advanced and ovarian endometriosis significantly affects in-vitro fertilization (IVF) outcomes through various mechanisms, including reduced ovarian responsiveness and increased cycle cancellation rates. Ovarian endometriomas can decrease the number of oocytes retrieved by up to 25%. Additionally, patients with endometriomas face specific risks during egg retrieval, such as endometrioma transfixation, which occurs in approximately 15% of cases, and follicular fluid contamination, which negatively impacts oocyte retrieval. Though rare, there are also concerns regarding an increased risk of pelvic abscesses during retrieval procedures. The role of surgery prior to IVF remains controversial, primarily due to the lack of a clear definition distinguishing fertility-optimizing surgery from procedures aimed at pain management or disease control. While some studies indicate that surgical excision may harm ovarian reserve, other evidence supports that selective surgical approaches—focused on restoring pelvic anatomy—can improve both spontaneous and assisted pregnancy rates. Given the complexities of endometriosis and its impact on fertility, surgical interventions should prioritize minimal intervention, aiming to preserve healthy ovarian tissue while reducing unnecessary dissection and limiting potential damage to ovarian function.

Methods

A 34-year-old gravida 0 was referred to our centre for the management of primary infertility. Her medical history included previous laparoscopic surgery with adhesiolysis, left ovarian cystectomy, and left salpingectomy for stage IV endometriosis performed by the referring physician. Transvaginal ultrasound revealed an adenomyotic uterus, kissing ovaries, with the left ovary containing a 5.2 cm endometrioma and the right ovary a 4 cm endometrioma. During pelvic examination by laparoscopy, an obliterated cul-de-sac, bilateral endometriomas, and a surgically absent left fallopian tube were noted, all encapsulated within the cul-de-sac with limited visibility of the ovarian cortex. Given the limited exposure, and the close anatomical proximity to the colon, pelvic wall, and uterus, the decision was made to focus on excising the endometriomas and performing minimal ovariolysis with the aim to optimize IVF outcomes and minimise potential surgical complications.

Results

Following an uneventful recovery from surgery, the patient underwent in vitro fertilization with embryo transfer. The IVF cycle was successful, and the patient achieved an uncomplicated pregnancy. She delivered at 39 weeks via caesarean section without any significant complications during pregnancy or delivery.

Conclusions

This case highlights that even in patients with advanced endometriosis and compromised ovarian reserve, fertility-enhancing surgery can improve pregnancy outcomes following IVF. This aligns with recent studies advocating for individualized and conservative surgical management. While the evidence regarding the absolute benefit of surgery prior to IVF remains varied, clinical cases like this demonstrate that a personalized, conservative surgical approach can effectively overcome the reproductive challenges posed by advanced endometriosis, leading to successful pregnancies. Treatment decisions should be based on a thorough patient evaluation, prioritizing ovarian preservation and the improvement of reproductive prognosis.

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Laparoscopic Management of Spondylodiscitis and Perforated Appendicitis Following Laparoscopic Sacrocolpopexy

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Background

Sacrocolpopexy is the gold standard treatment for pelvic organ prolapse (POP). Although fixation to the sacral promontory with sutures or tackers is usually safe, rare complications such as spondylodiscitis (SD) can occur, leading to mesh removal, reoperation, or permanent disability. This video presents a complex case of SD with appendix perforation following laparoscopic hysterectomy and sacrocolpopexy, requiring two additional surgeries due to tacker infections.

Methods

The video documents the patient's clinical course and the third surgery, during which all tackers were removed, and the perforated appendix was excised.

Results

A 48-year-old woman presented with pelvic pain two months after laparoscopic hysterectomy and sacrocolpopexy at another hospital. The mesh had been introduced via the vaginal route and fixed with tackers—both potential sources of infection. She was hospitalized due to severe pelvic pain and was diagnosed with SD, recurrent prolapse, and pelvic cellulitis. Initial treatment involved oral antibiotics and surgery at another centre with mesh removal, sacrospinous fixation and local debridement. However, symptoms persisted, with elevated CRP levels and worsening back pain. She was admitted to our clinic, received teicoplanin and ciprofloxacin for 19 days, but MRI showed progression with paravertebral inflammation around the iliac artery and tacker infection near L5-S1, measuring 4 mm in size. Gynaecologic exam revealed grade 2–3 cuff prolapse and visible sutures.

A third surgery was performed. Intraoperatively, mesh and tackers were found at the lumbosacral joint. The appendix was elongated, dilated, and perforated, adherent to the promontory. The mesh, tackers, and fibrotic tissue were removed; appendectomy was performed. *Pseudomonas aeruginosa* was identified in the histopathological examination, and antibiotics were switched to meropenem and colistin. The patient's symptoms resolved, and imaging improved within three weeks.

Conclusions

Spondylodiscitis is a rare but serious complication of sacrocolpopexy. Early recognition, timely mesh and tacker removal, and a multidisciplinary approach are critical, especially in complex presentations involving secondary infections such as appendix perforation.

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<https://player.vimeo.com/video/1120565053?autoplay=1>

Laparoscopic secondary cytoreduction in recurrent ovarian cancer

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Background

We aimed to present a case managed with minimally invasive surgery due to recurrent ovarian cancer.

Methods

A 44-year-old patient who underwent cytoreductive surgery 4 years ago due to high-grade serous ovarian cancer and then received 6 cycles of chemotherapy, was diagnosed with left obturator and right diaphragmatic lesions in CT and PET-CT imagings taken in February 2025 after approximately 42 months of disease-free follow-up. The patient, whose first operation was performed through a midline incision, was observed to have extensive adhesions after entry from the Palmer point. After widespread adhesiolysis, the obturator fossa was reached with left pelvic retroperitoneal dissection. Perioperative radiology consultation determined that the pathological lymph nodes were lateral to the left edge of the vaginal vault. With the dissection performed, the lymph nodes were released intact and excised. For diaphragmatic implant, an incision was made from the periphery of the lesion with ultrasonic forceps, leaving a surgical margin of approximately 5 mm. The lesion was released intact and taken out of the abdomen. The diaphragm defect was closed continuously with ethibond 3.0 suture material.

Results

Operation has been completed laparoscopically without any residual lesion.

Conclusions

In selected cases, in patients with recurrent ovarian cancer who are planned to undergo secondary cytoreduction, minimally invasive surgery may be preferred due to its advantages such as less pain, less bleeding, early ambulation, and allowing early initiation of adjuvant treatment in patients who require it.

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Salpinx Loop Technique for Tubal Sterilization Performed via Transvaginal Natural Orifice Transluminal Endoscopic Surgery (vNOTES-SLT): A Novel Approach to Minimally Invasive Sterilization

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Background

Transvaginal natural orifice transluminal endoscopic surgery (vNOTES) offers a scarless and minimally invasive route for gynaecologic procedures, including tubal sterilization. However, intracorporeal ligation of the fallopian tubes during vNOTES may be technically challenging due to limited instrument triangulation and field depth. We introduce the Salpinx Loop Technique (SLT), a novel modification that utilizes under-uterine counter-traction to form a looped ampullary segment, aiming to enhance accessibility and control during tubal occlusion.

Methods

We performed the vNOTES-SLT technique in a 41-year-old patient with no significant medical history who requested permanent sterilization. After transvaginal port placement and creation of pneumoperitoneum, the ampullary portion of each fallopian tube was gently retracted beneath the posterior uterine wall toward the ipsilateral cornua, forming a reversed U-shaped loop. Simultaneously, the uterus was anteverted to enhance visualization and access. The loop was ligated using bipolar energy.

Results

The vNOTES-SLT technique was successfully performed bilaterally in the patient. The mean operative time was 8.42 minutes. No intraoperative complications or conversion occurred. Postoperative recovery was uneventful. The patient was discharged at the 6th postoperative hour. Our case study showed improved accessibility and ligation stability with the use of under-uterine loop formation.

Conclusions

The SLT enhances the precision and ergonomics of tubal ligation during vNOTES by improving anatomical access through under-uterine medialization. Beyond its technical feasibility and reproducibility, SLT is well-aligned with Enhanced Recovery After Surgery (ERAS) principles by minimizing tissue trauma, reducing operative time, and facilitating rapid recovery and early discharge. Further studies are warranted to assess long-term efficacy and enable standardization through structured training.

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Incidentally Detected Ectopic Pregnancy and Its Minimally Invasive Management

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Background

In patients diagnosed with ectopic pregnancy, timely management is crucial to prevent complications and preserve reproductive health. Minimally invasive surgical intervention, such as laparoscopic management, is often preferred due to its benefits in reducing recovery time and postoperative morbidity.

Methods

This video illustrates a laparoscopic intervention performed on a patient who presented to our clinic with a positive HPV status and a medical history of amenorrhea lasting 2 months. During the evaluation, ultrasonography revealed an incidental left adnexal mass, which was further assessed with detailed imaging. The findings confirmed the presence of an embryo in the left fallopian tube, consistent with 8 weeks of gestation, but without cardiac activity.

After confirming the diagnosis with B-HCG values, a laparoscopic surgical approach was planned. The procedure involved careful dissection to access the affected fallopian tube while preserving surrounding structures. Following the removal of the ectopic tissue, meticulous inspection of the surgical field was performed to ensure haemostasis and prevent complications.

Results

The surgical procedure was completed successfully without any intraoperative complications. Postoperative imaging confirmed the absence of residual ectopic tissue and the patient's condition was stable.

Conclusions

Laparoscopic management of ectopic pregnancy is a safe and effective approach that minimizes patient morbidity and promotes quicker recovery. This technique allows for the preservation of reproductive potential, especially important in young women. Careful patient selection and surgical expertise in pelvic anatomy are key to achieving optimal outcomes.

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Laparoscopic hysterectomy in a patient with extensive abdominal wall and pelvic adhesions following prior myomectomy

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Background

Previous abdominal surgeries, particularly myomectomy, often result in dense adhesions that complicate subsequent pelvic procedures. These adhesions increase the difficulty and risk associated with laparoscopic surgery.

Methods

We present a video case of laparoscopic hysterectomy in a patient with extensive abdominal wall and pelvic adhesions secondary to a prior open myomectomy. Entry was achieved using a careful open (Hasson) technique due to dense adhesions between the anterior abdominal wall and underlying bowel and omentum. Extensive adhesiolysis was performed to mobilize these structures and expose the pelvic organs. Sharp and blunt dissection techniques were meticulously used to separate severe adhesions between the uterus, bladder, and rectum, with particular care taken during bladder dissection.

Results

Despite the complexity and significant adhesiolysis required, the laparoscopic total hysterectomy was completed without intraoperative complications and with minimal blood loss. Postoperative recovery was uneventful.

Conclusions

This case demonstrates that laparoscopic hysterectomy is feasible and safe in patients with extensive abdominal and pelvic adhesions when performed by experienced surgeons. Advanced laparoscopic skills, careful dissection, and patience are crucial in challenging reoperative fields. Prior open surgery should not be considered an absolute contraindication for minimally invasive approaches.

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Step-by-Step Guide to HyCoSy: A Visual Walkthrough of Infertility Assessment

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Background

To demonstrate the complete HyCoSy (Hysterosalpingo-Contrast Sonography) procedure was performed in a secondary care setting, highlighting key steps, protocols, and practical considerations. The goal is to support clinicians and trainees in adopting a standardised, safe, and effective approach to infertility assessment.

Methods

A visual and narrated video walkthrough illustrates the eight key stages of the HyCoSy procedure:

1. Pre-procedure preparation
2. Equipment preparation
3. Baseline transvaginal ultrasound
4. Speculum insertion and cervical cleaning
5. Catheter insertion
6. Contrast injection under ultrasound guidance
7. Assessment and documentation
8. Post-procedure care

Results

The video was recorded in a real-world secondary care setting using standard NHS protocols. The video successfully demonstrates a structured, reproducible approach to HyCoSy, providing clarity on technique and workflow. It enables viewers to understand how to optimise image acquisition, ensure patient comfort, and interpret findings effectively

Conclusions

This video serves as an educational resource for healthcare professionals involved in fertility investigations. By visually standardising the HyCoSy procedure and integrating practical insights, it aims to enhance training, support protocol adherence, and ultimately improve the quality and accessibility of infertility assessment services.

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Bloodless laparoscopic hysterectomy and bilateral adnexectomy using Thunderbeat: a video demonstration

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Background

Minimally invasive hysterectomy is the preferred approach for benign and early malignant gynaecologic conditions. Achieving effective haemostasis with minimal thermal spread is crucial to ensure a safe and efficient procedure.

Methods

We present a video case of a 54-year-old woman undergoing laparoscopic total hysterectomy with bilateral adnexectomy using the Thunderbeat advanced energy device. Thunderbeat combines ultrasonic and bipolar energy in a single instrument, allowing simultaneous tissue sealing and cutting. The entire procedure was performed using Thunderbeat for vessel sealing, tissue dissection, and transection, without the need for additional energy sources or clips.

Results

The surgery was completed smoothly with minimal blood loss, no requirement for haemostatic sutures, and excellent visualization throughout. Uterine artery sealing and transection were achieved quickly and effectively without thermal injury to adjacent tissues. Bilateral adnexectomy was completed with ease while maintaining haemostasis.

Conclusions

This case highlights the efficiency and safety of Thunderbeat as a standalone energy device for bloodless laparoscopic hysterectomy and adnexectomy. The hybrid ultrasonic-bipolar technology facilitates faster operative times, reduces instrument exchanges, and minimizes intraoperative bleeding. Thunderbeat represents a reliable solution for precision and rapid haemostasis in minimally invasive gynecologic surgery, encouraging broader adoption of advanced energy technologies.

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Stepwise Management of a Sigmoid Colon-Migrated IUD: Combined Laparoscopic Inspection and Colonoscopic Retrieval

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Background

This video article presents a rare case of transmural intrauterine device (IUD) migration into the sigmoid colon and highlights the role of a stepwise, multidisciplinary approach using combined colonoscopy and laparoscopy for safe retrieval and evaluation of bowel integrity.

Methods

A 28-year-old woman with three prior vaginal deliveries had a Copper-T IUD inserted in 2023. At 3-month follow-up, the device was found to have migrated outside the uterine cavity. A diagnostic laparoscopy at an outside centre failed to locate or retrieve the IUD. Upon referral, she was asymptomatic with normal examination findings. Abdominal CT revealed the IUD within the right pelvic fossa, suggesting rectosigmoid colon involvement. After bowel preparation, the patient underwent combined laparoscopy and colonoscopy under general anaesthesia. Dense adhesions between the rectosigmoid colon and abdominal wall limited laparoscopic visibility. Colonoscopy revealed an intact IUD embedded 18 cm from the anal verge, which was removed using snare traction. A second-look laparoscopy and intra-abdominal air leak test were performed to assess bowel integrity.

Results

The IUD was successfully retrieved endoscopically without fragmentation. No intraperitoneal leakage was observed, and the suspected perforation site appeared to be sealed by surrounding tissue. The patient recovered uneventfully, resumed oral intake six hours postoperatively, and was discharged on day two. At six-week follow-up, she remained asymptomatic with normal pelvic ultrasound.

Conclusions

This case illustrates that sigmoid colon migration of an IUD, though rare, may be effectively managed through a combined endoscopic and laparoscopic strategy. A failed laparoscopic retrieval does not preclude endoscopic success. Collaborative planning and intraoperative assessment are essential to optimize outcomes and minimize surgical morbidity.

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Labial Fusion Causing Urinary Obstruction and Menstrual Problems

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Background

Labial fusion is a rare condition in adult women, often linked to chronic inflammation, trauma, or hormonal deficiency. It can result in significant complications, including urinary retention and menstrual outflow obstruction. Timely diagnosis and appropriate management are essential to prevent further morbidity.

Methods

A 42-year-old woman presented with a four-month history of amenorrhea and a recent three-day history of urinary retention. She reported no previous urinary tract infections but complained of severe lower abdominal pain. Physical examination revealed complete labial fusion, obscuring both the urethral and vaginal openings. Under local anaesthesia, labioplasty was performed to restore anatomical patency. The patient was discharged the same day with no immediate complications.

Results

Urinary function was immediately restored postoperatively, and the patient reported significant pain relief. Menstrual flow resumed during the next expected cycle. At the two-week follow-up, she reported complete resolution of symptoms. Examination confirmed a well-healed perineum without recurrent adhesion.

Conclusions

Though uncommon in adults, labial fusion should be considered in women presenting with both menstrual and urinary obstruction. Simple surgical intervention can lead to rapid and complete symptom resolution. This case highlights the importance of early recognition and effective management in preventing avoidable complications.

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Safe Dissection of a Ureter-Adherent Ovarian Lesion in Minimally Invasive Hysterectomy

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Background

To illustrate dissection of a 8cm right ovarian lesion adherent to the ureter and the surrounding tissue while performing a laparoscopic total hysterectomy with bilateral salpingo-oophorectomy

Methods

A 47-year-old patient, who has been in menopause for 1.5 years and has no additional complaints, presented to the outpatient clinic with an 8 cm right adnexal mass and was referred for further evaluation. She has no known medical conditions and no history of surgery other than a laparoscopic operation for a right endometrioma. She is not on any regular medication and smokes 20 cigarettes per day. Preoperative routine assessments were performed. Cervical cytology (Pap smear) was negative. MRI imaging revealed a cyst in the right adnexal region measuring 8×7 cm without solid components, as well as uterine fibroids, the largest measuring 4 cm. No findings suggestive of malignancy were detected. Tumour markers were within normal limits (CA-125:12 U/mL, CA 19-9: 8 U/mL, CA 15-3: 27 U/mL, CEA: 3,4 U/mL). Other blood test results were unremarkable. The patient underwent surgery with a planned laparoscopic hysterectomy and bilateral salpingo-oophorectomy, along with intraoperative frozen section analysis. Upon entering the abdominal cavity, an approximately 8 cm mass was observed in the right adnexal region, adherent to the surrounding tissue. After careful dissection and mobilization of the mass, the uterus and adnexa were removed from the abdominal cavity through the vaginal os with the aid of a manipulator. The mass was placed in an endobag inserted transvaginally and sent for pathological examination with its integrity preserved and without contact with surrounding tissues. As no evidence of malignancy was observed on frozen section analysis, the procedure was concluded

Results

The operation lasted approximately 2.5 hours and was completed without any complications, such as bleeding or ureteral injury. The patient did not experience any additional complaints during the postoperative period, both during follow-up in the ward and at the first outpatient clinic visit after surgery.

Conclusions

The removal of large adnexal masses, especially in cases with suspected malignancy—although not present in this case—without fragmentation and ensuring that dissection is performed carefully without damaging surrounding structures, requires an extensive experience. This case serves as a good example in this regard

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Laparoscopic Management of a Peritoneal Ectopic Pregnancy; A Rare and Silent Presentation

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Background

Peritoneal ectopic pregnancy is a rare but serious form of extrauterine gestation, accounting for approximately 1% of all ectopic pregnancies. Its diagnosis can be delayed, particularly in asymptomatic cases, increasing the risk of complications. This video article aims to present the diagnostic process and laparoscopic management of an asymptomatic peritoneal ectopic pregnancy.

Methods

A reproductive-aged woman presented to Ankara University with a complaint of delayed menstruation, but no pelvic pain or vaginal bleeding. Physical examination was normal. Initial serum beta-hCG was 2,237 mIU/mL, and progesterone was 15 ng/mL. Transvaginal ultrasonography showed no intrauterine gestational sac or adnexal pathology. Serial beta-hCG testing demonstrated a rising trend (3,682 mIU/mL at 48 hours). Endometrial curettage was performed and showed no chorionic villi. Methotrexate was administered intramuscularly at a dose of 50 mg/m², but beta-hCG continued to rise (6,374 mIU/mL on day 4, 7,988 mIU/mL on day 7). Diagnostic laparoscopy was performed.

Results

Laparoscopy revealed a 1 cm ectopic implantation site located on the peritoneal surface near the left uterosacral ligament. Both fallopian tubes were normal and patent. The ectopic focus was excised by blunt dissection and retrieved through a 10 mm trocar. Residual tissue was cauterized using bipolar energy. A simple cyst on the right ovary was aspirated during the same procedure. Postoperative beta-hCG levels decreased by 50% on the first day. The patient was followed weekly until beta-hCG levels dropped below 5 mIU/mL, confirming complete resolution. No intraoperative or postoperative complications occurred.

Conclusions

This case demonstrates that peritoneal ectopic pregnancies may present without classical symptoms, such as pain or bleeding, and highlights the importance of clinical suspicion in the setting of rising beta-hCG and inconclusive imaging. Laparoscopy remains the gold standard for both diagnosis and treatment in such cases, enabling effective resolution and preservation of reproductive potential.

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Thin endometrium due to Uterine Mullerian anomaly

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Background

Thin endometrium is defined as a mid-luteal endometrial thickness ≤ 7 mm. Thin Endometrium can affect endometrial tolerance, leading to lower embryo implantation rates and clinical pregnancy rates, and is also associated with impaired outcomes from assisted reproductive treatment.

The most common causes of thin endometrium are previous uterine curettages, uterine surgeries and sometimes Müllerian uterine anomalies. In this case, we report the pregnancy achieved with IVF treatment after hysteroscopy and medical treatments of the patient who complained of amenorrhea without any uterine surgery or curettage

Methods

27 years old patient applied to our clinic with the complaint that she had been married for 5 years and had never been able to get pregnant. The patient also had a complaint of amenore. In the ultrasonographic examination, the uterus was hypoplastic and the endometrium was measured as 3 mm. 6-7 antral follicles were observed bilaterally in the ovaries. In the hysterosalpingography, the uterine cavity was in a very distinct T shape.

The patient first had difficulty entering the cavity with office hysteroscopy. However, the uterine cavity was observed to be very narrow and hypoplastic. Then, T Shape repair was performed with 7 mm operative hysteroscopy. A copper T IUD was placed in the uterine cavity. Approximately 2 weeks later, IUD-guided office Hysteroscopy and subendometrial PRP were performed. The patient, who was also given oestradiol treatment, started to menstruate after 1 month. After 2 months, the IUD was removed, and then office hysteroscopy was performed again. The cavity had a normal structure and the bilateral tubal ostia could be observed.

With IVF treatment two 5AA quality embryo, were frozen and stored. Approximately 5 months later, endometrium thickness in the midluteal was 5.5 mm. With office hysteroscopy again, the adhesions in the cavity were opened and an IUD was placed. The patient, whose IUD remained in the cavity for approximately 6 months, was given continuous hormone replacement therapy.

Frozen embryo transfer was started with high dose oestrogen therapy. The endometrium thickness of the patient, whose IUD was removed on the 7th day, was measured as 7.1 mm, and 1 embryo was transferred. However, the pregnancy result was reported as negative.

Results

After the IUD was removed, the patient's hormone replacement therapy was continued, and the endometrium was prepared again with high dose oestrogen. Embryo transfer was performed when the endometrium was 7 mm. The HCG value on Day 12 after transfer was reported as 112 mIU/ml and 2 days later as 229 mIU/ml.

Conclusions

Due to uterine anomalies, patients may apply to the clinic with thin endometrium or even amenorrhea as in this case. Successful results can be achieved with appropriate hysteroscopic surgery, IUD applications and subendometrial PRP.

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Laparoscopic hysterectomy and sacrocolpopexy with mesh fixation using EndoFast Tucker system

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Background

Sacrocolpopexy is the gold standard surgical treatment for apical pelvic organ prolapse, offering durable anatomical and functional results. Minimally invasive approaches combined with advanced fixation devices can improve surgical efficiency and outcomes.

Methods

We present a case of a 58-year-old woman with symptomatic stage III uterovaginal prolapse who underwent laparoscopic total hysterectomy followed by laparoscopic sacrocolpopexy. After hysterectomy, a synthetic Y-shaped mesh was placed to support the vaginal apex. The mesh arms were sutured to the vaginal walls. For sacral promontory fixation, the EndoFast Tucker system was used to anchor the mesh to the anterior longitudinal ligament without traditional suturing. The peritoneum was then closed over the mesh to prevent bowel contact.

Results

The procedure was completed without complications, with minimal blood loss and optimal mesh tension and positioning. The EndoFast Tucker enabled atraumatic and secure mesh fixation, reducing operative time and technical complexity.

Conclusions

This case demonstrates the feasibility and technical advantages of laparoscopic sacrocolpopexy using the EndoFast Tucker system for mesh fixation. The device facilitates safe, reproducible, and efficient sacral anchoring, enhancing minimally invasive pelvic reconstructive surgery. Combining hysterectomy with laparoscopic sacrocolpopexy provides excellent anatomical restoration for uterovaginal prolapse patients.

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"First Da Vinci Single Port Sacrocolpopexy for Multicompartmental Pelvic Organ Prolapse: A Complete Surgical Video"

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Background

Pelvic organ prolapse (POP) affects 3–8% of women and significantly impairs quality of life, with an 11% lifetime risk of requiring surgery. Minimally invasive sacrocolpopexy is the gold standard for treating apical and multicompartmental prolapse, offering high success rates and reduced recurrence compared to other techniques. Robotic surgery demonstrates similar safety and effectiveness to laparoscopy.

Methods

A 72-year-old woman with symptomatic grade IV multicompartmental prolapse, classified using the Halfway System (HWS), underwent subtotal hysterectomy, bilateral salpingo-oophorectomy followed by sacrocolpopexy using an innovative single-port robotic platform.

Results

The total operative time was 180 minutes, with 150 minutes of robotic console time. No intraoperative or postoperative complications were observed. The patient was discharged on the third postoperative day. At the one-month follow-up visit, pelvic examination revealed a stage I prolapse, with complete resolution of the symptoms.

Conclusions

Single-port robotic sacrocolpopexy is a technically viable and safe option for managing advanced multicompartmental POP. Preliminary outcomes suggest favorable results in terms of operative time, aesthetics, postoperative discomfort, and hospitalization duration. Further studies with larger patient cohorts and longer follow-up periods are necessary to fully assess clinical effectiveness, cost-efficiency, and patient-reported outcomes. The platform's triangulation capabilities facilitated a precise and effective approach. Further research is warranted.

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Clamping down on bleeding: The bulldog advantage in laparoscopic myomectomy

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Background

Haemostasis remains a major challenge during laparoscopic myomectomy due to the uterus's rich vascular supply and risk of significant bleeding. Common strategies include uterotonic or vasoconstrictive agents or temporary arterial occlusion. Temporary arterial occlusion using vascular clamps provides direct, reversible mechanical control of blood flow, reducing bleeding without systemic effects. However, it requires precise anatomical knowledge and surgical skill to avoid vascular injury.

This video aims to present an alternative technique for significantly reducing uterine blood supply during laparoscopic myomectomy, utilizing temporary bilateral uterine artery occlusion with Bulldog clamps.

Methods

Surgical video of 39 years old woman who undergone laparoscopic myomectomy. Intraoperative temporary uterine artery occlusion was achieved using bilateral Bulldog Clamps. The patient gave consent before the operation regarding use of surgical video for scientific purposes without disclosing any personal detail.

Results

In this case, instead of high-level occlusion, bulldog clamps were placed directly on the uterine arteries bilaterally. This simplified the procedure by avoiding dissection of proximal vessels while still achieving effective haemostasis.

Conclusions

In this patient, uterine artery occlusion allowed safe myoma enucleation with minimal blood loss and no complications. This case supports uterine artery clamping as a practical, effective variation of arterial occlusion during laparoscopic myomectomy.

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A Body in Pain, A Life on Hold: Multidisciplinary Approach and Laparoscopic Surgery in a Young Women with Deep Infiltrating Endometriosis- A Video Case Presentation

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Background

This case report presents a young woman diagnosed with deep infiltrating endometriosis (DIE), focusing on the complexities of multidisciplinary decision-making, surgical strategy, and the psychosocial burden associated with this chronic and debilitating condition. The goal is to highlight the importance of patient-centred care and individualized treatment approaches in severe DIE cases, supported by intraoperative video documentation (1,2).

Methods

A 36-year-old woman presented with primary dysmenorrhea since adolescence, chronic pelvic pain, dyspareunia, and infertility. Despite multiple consultations, she had received only NSAIDs, with minimal relief. Her medical history included one caesarean section, five unsuccessful IVF attempts, fibromyalgia, and depression managed with SSRIs. On examination, she showed emotional distress, and pelvic evaluation revealed marked tenderness at the posterior fornix. Transvaginal ultrasound demonstrated bilateral ovarian endometriomas (4–5 cm) and kissing ovaries. Conservative management with dienogest 2mg/day, psychiatric and physiotherapy referrals, dietary counselling, and pain management was initiated but failed to control symptoms. Laparoscopy revealed extensive adhesions and DIE nodules on the uterosacral ligaments, rectum, parametrium, ureters, cervix, and fallopian tubes. Complete excision of visible lesions, bilateral cystectomy, and left salpingectomy were performed. A postoperative pelvic abscess was managed conservatively (1,3). Due to symptom recurrence after three months, a second surgery laparoscopic total hysterectomy and bilateral salpingo-oophorectomy was carried out. The patient also reported stabbing pain at the lateral aspects of the caesarean scar. A third surgery confirmed microscopic endometriotic nodules in those areas, which were excised (1).

Results

Histopathological analysis confirmed endometriosis in all excised areas. Post operative recovery was uneventful, with significant reduction in pain scores and improvement unphysical function. The patient remains under psychiatric care and continues with pelvic floor physical therapy and cognitive behavioural therapy.

Conclusions

This case illustrates the progressive and treatment-resistant nature of DIE. Radical surgical intervention may be warranted when conservative approaches fail, particularly in patients with psychiatric comorbidities (1,4). The surgical complexity necessitated nerve-sparing techniques due to the proximity of lesions to vital pelvic structures. Additionally, the case emphasizes the importance of recognizing atypical DIE sites such as caesarean section scars. Video documentation supports

anatomical education and technical proficiency. DIE affects not only reproductive health but also emotional and sexual well-being, necessitating a comprehensive, multidisciplinary, and patient-focused treatment paradigm. Early diagnosis of endometriosis plays a pivotal role in optimizing clinical outcomes. When recognized promptly, the disease can often be managed effectively with medical therapy, dietary regulation, and supportive care, thereby potentially delaying or even obviating the need for surgical intervention. For this reason, endometriosis should be consistently considered in the differential diagnosis of patients presenting with chronic pelvic pain, dyspareunia, or infertility.

References

1. Ferrero S, Vercellini P, Abbott J. Deep infiltrating endometriosis: Definition, diagnosis, and management. *J Am Assoc Gynecol Laparosc.* 2004 May;11(2):153-61. doi:10.1016/s1074-3804(05)60190-9.
2. Chapron C, Marcellin L, Borghese B, Santulli P. Rethinking mechanisms, diagnosis and management of endometriosis. *Nat Rev Endocrinol.* 2019 Nov;15(11):666-682. doi:10.1038/s41574-019-0245-z. <https://pubmed.ncbi.nlm.nih.gov/31488888/>
3. Meuleman C, Tomassetti C, D; Hoore A, et al. Surgical treatment of deeply infiltrating endometriosis with colorectal involvement. *Hum Reprod Update.* 2011;17(3):311–326. doi:10.1093/humupd/dmq057
4. Leyland N, Casper R, Laberge P, Singh SS. Endometriosis: diagnosis and management. *J Obstet Gynaecol Can.* 2010;32(7 Suppl 2):S1–S32.

<https://player.vimeo.com/video/1090196984?autoplay=1>
<https://esge.covr.be/cmdocumentmanagement/conferencemanager/documents/api/getdocument/14815/cmabstsms/0000228680/fe5d7d533d6796cdcf926af965ebe8a87d179e3cc81a8110ed0662ca5caba283>

Successful Management of Cervical Insufficiency with Laparoscopic Abdominal Cerclage: Case Report

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Background

To present two cases of cervical insufficiency successfully managed with laparoscopic abdominal cerclage following prior failed transvaginal cerclage, highlighting the feasibility and safety of this approach in both pregnant and non-pregnant patients.

Methods

Two patients diagnosed with cervical insufficiency, both with a history of prior failed transvaginal cerclage, were selected for laparoscopic abdominal cerclage. One patient was non-pregnant at the time of surgery, while the second was 8 weeks pregnant. In both cases, the indication for transabdominal cerclage was established based on their obstetric history. A laparoscopic transabdominal approach was used to place a nonabsorbable Mersilene tape at the level of the internal cervical os following bladder dissection and exposure of the lower uterine segment. The tape was tied posteriorly with minimal uterine manipulation, and haemostasis was ensured before completion.

Results

Both procedures were successfully completed without intraoperative complications. The non-pregnant patient recovered uneventfully, was discharged on postoperative day one, and is currently 18 weeks pregnant with regular antenatal follow-up. The pregnant patient tolerated the procedure well, with confirmed foetal cardiac activity and no signs of uterine irritability or complications. Follow-up visits showed intact cerclages and satisfactory healing. Both patients continue antenatal care, with a caesarean delivery planned at term for the pregnant patient.

Conclusions

Laparoscopic abdominal cerclage is a valuable and safe surgical option for women with cervical insufficiency, particularly in cases with a history of failed transvaginal cerclage. It offers clear advantages, including reduced postoperative pain, shorter hospital stay, and faster recovery. Our cases demonstrate that, when performed by experienced surgeons with careful technique and minimal uterine manipulation, laparoscopic cerclage is feasible in both pregnant and non-pregnant patients. Importantly, abdominal cerclage should be considered the next step in management for patients with clear indications based on prior obstetric history or anatomical factors, supporting its role as an effective strategy in selected high-risk populations.

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Complete Uterine and Vaginal Septum: Clinical Presentation and Surgical Management

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Background

Müllerian anomalies are developmental defects resulting from abnormal fusion or resorption of the paramesonephric ducts. A complete uterine septum with a longitudinal vaginal septum is a rare but clinically significant anomaly. Although often asymptomatic, such anomalies may lead to dyspareunia, obstructive menstrual symptoms, infertility, or adverse pregnancy outcomes including recurrent miscarriage, preterm birth, and malpresentation. According to the 2024 ASRM guideline, surgical intervention is recommended in symptomatic patients and those with a history of pregnancy loss, while a shared decision-making approach is suggested for patients with infertility.

Methods

We present the case of a 24-year-old nulligravid woman with complaints of severe dysmenorrhea and dyspareunia. Physical examination revealed a longitudinal vaginal septum. Imaging with three-dimensional transvaginal ultrasound (3D-TVUS) and MRI demonstrated a complete uterine septum extending to the internal os, with a single external uterine contour and duplicated endometrial cavity. Under general anaesthesia, a vaginoscopic and hysteroscopic approach was used. The vaginal septum was dissected at the midline to avoid injury to adjacent structures. Hysteroscopic metroplasty was performed using cold scissors and bipolar energy to minimize adhesion formation. Both endometrial cavities were unified under direct visualization, and the septum was resected up to the level of the tubal ostia.

Results

The procedure was completed successfully without intraoperative complications. Postoperative evaluation confirmed the restoration of normal uterine anatomy, with symmetric visualization of both tubal ostia at the cervical level. No postoperative adhesions or infections were observed. The patient reported significant improvement in symptoms and expressed satisfaction with the outcome. Fertility planning is ongoing, with conception attempts scheduled after the recommended healing interval of 1–2 months.

Conclusions

Complete uterine and vaginal septa, while rare, can cause significant gynecological and reproductive morbidity. Diagnosis should be confirmed using 3D-TVUS and/or MRI. In symptomatic patients, especially those planning for future fertility, minimally invasive surgical correction provides both anatomical and symptomatic relief. Adherence to guideline-recommended techniques, including bipolar energy use and midline dissection, enhances safety and surgical outcomes.

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A Case Report Illustrating the Limits of Imaging and Conservative Treatment in Large Multilobar Endometriomas

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Background

Endometriosis affects up to 15% of women of reproductive age, with 30–50% experiencing infertility. Endometriomas can compromise ovarian reserve, and their management must balance symptom relief and fertility preservation. This case highlights diagnostic challenges and limitations of conservative surgical management in large, multilobar endometriomas.

Methods

We present a 42-year-old woman with primary infertility, prior endometrioma surgery, and severe pelvic pain. Transvaginal ultrasound revealed three right ovarian endometriomas and a 79 mm left ovarian endometrioma. No magnetic resonance imaging (MRI) was initially performed. Due to her symptoms and fertility concerns, laparoscopic sclerotherapy was planned.

Intraoperative findings showed a large (10 cm), multilobar endometrioma in the right ovary, displaced by adhesions to the left pelvis. The left ovary appeared small and healthy. The procedure involved ethanol sclerotherapy and laser vaporization of the largest lobes due to the size of the cyst. Postoperative MRI revealed a persistent 46 mm endometrioma, suggesting incomplete treatment.

Results

Ultrasound is the first-line imaging tool, with >90% sensitivity and specificity. However, in complex or multilobar cysts, MRI may be essential for accurate mapping. Sclerotherapy is a conservative option suited for fertility preservation but carries risks of recurrence, incomplete ablation, and peritonitis. Additionally, ovarian stimulation during artificial reproductive technologies (ART) may exacerbate endometriomas through cyst enlargement or rupture.

Conclusions

This case illustrates the diagnostic limitations of ultrasound in complex endometriomas and the potential inadequacy of sclerotherapy in large, multilobar cases. MRI should be considered preoperatively for comprehensive evaluation. A tailored surgical approach remains crucial, particularly before initiating ART.

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Single Port Meshless Laparoscopic Pectopexy Procedure

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Background

Laparoscopic pectopexy has emerged as a novel alternative to sacrocolpopexy in the surgery of apical prolapse, especially in cases where avoiding mesh-related complications is a priority. Originally introduced by Banerjee and Noé (1) using mesh for fixation to the pectineal ligaments, the technique has evolved toward mesh-free adaptations due to reports of erosion, pain, and other long-term complications (2,3). Minimally invasive approaches, including single-port laparoscopy, have further advanced the technique by reducing surgical trauma and enhancing cosmetic outcomes.

Methods

We present the first reported case of mesh-free single-port laparoscopic pectopexy performed in a 52-year-old woman with stage 4 uterine prolapse and a suspected 10 cm uterine leiomyoma. The procedure began with resection of a concomitant 8 cm umbilical hernia, followed by the insertion of a V-port through the hernia site. A total laparoscopic hysterectomy was performed, after which the uterus and adnexa were removed via the single port. Meshless pectopexy was then initiated. The vaginal cuff was manipulated transvaginally, and non-absorbable 2-0 polyester sutures were placed through the cuff without penetrating the mucosa. The peritoneum was dissected to expose the pectineal ligaments bilaterally, taking care to identify and preserve the iliac vessels. The sutures were passed through the ligaments and tied intracorporeally without tension. The peritoneal defect was closed using a barbed absorbable suture to prevent potential bowel entrapment.

Results

Our patient was discharged from hospital at postoperative day 2 and her follow-up is resuming for now.

Conclusions

Mesh-free single-port laparoscopic pectopexy is a promising technique that combines the safety of mesh avoidance with the advantages of minimally invasive surgery. While our initial outcome was favourable, consistent with existing literature (4–7) further prospective studies are needed to validate the long-term efficacy and reproducibility of this approach.

References:

1. Banerjee C, Noé KG. Arch Gynecol Obstet. 2011;284(3):631–
2. Bakir MS, et al. Gynecol Minim Invasive Ther. 2020;9(1):42.
3. Obut M, et al. Gynecol Minim Invasive Ther. 2021;14;10(2):96-103.
4. Erdem B, et al. Int Urogynecology J. 2025;1;
5. Rovner E, et al. Neurourol Urodyn. 2020;39 Suppl 3:S132–9.
6. Aleksandrov A, et al. Facts Views Vis ObGyn. 2021;13(2):179–81.
7. Biyik I, et al. Gynecology and Minimally Invasive Therapy. 2025 (Article in press)

<https://player.vimeo.com/video/1090229166?autoplay=1>

<https://esge.covr.be/cmdocumentmanagement/conferencemanager/documents/api/getdocument/14476/cmabstms/0000147610/116e5ad2ec33c5d4d2bf8f59c5b8dde129ce10c3a9d4d74c1d37a3f9906bee39>

Supracervical hysterectomy in advanced endometriosis and adenomyosis - why isn't it always a good idea

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Background

Endometriosis affects 6% to 15% of the female population of childbearing potential, with a wide range of symptoms and complaints. Involvement of adjacent systems, such as digestive and/or urinary tracts, is one of major consequences of endometriosis. Depending on the location of lesions, the disease may produce obvious symptoms, or none at all. Adenomyosis is a frequent feature in these patients as well, responsible for a substantial proportion of symptoms. Therefore, patients not seeking conception and over 40-45 years of age are sometimes offered radical destructive surgery, involving hysterectomy. There is continuous discussion among medical professionals and between doctors and patients as to whether to conserve the cervix or proceed with total laparoscopic hysterectomy (TLH).

The objective was to present a case of challenging surgery for recurrent endometriosis/adenomyosis with ureteral and intestinal involvement following supracervical hysterectomy performed as part of initial surgery. A retrospective review of our surgical database has also been performed, involving a period from January 1st, 2019, through May 29th, 2025 (1424 total records).

Methods

Surgery was performed in a 44-year-old patient who presented in 2023 with a history of supracervical laparoscopic hysterectomy (SLH) back in 2019, with right-sided ureteral distention and hydronephrosis, managed by urologists with a catheter insertion. Symptoms included cycle-dependent pain (10/10), dyspareunia (7/10), with no particular back pain. Echography showed numerous adenomyosis-type lesions protruding from the cervical stump, with two lesions seemingly invading the bowel, and one compressing the ureter. Extensive surgery was needed, with adhesion deliberation, bowel shaving and suturing, and right-sided ureteral decompression with cervix excision.

Results

We have performed a total of 20 surgeries in such patients, with all but three presenting with urinary and/or digestive tract involvement. All patients underwent initial surgery elsewhere. Adenomyosis was confirmed in all postoperative specimens of cervical stumps.

Of all 316 hysterectomies performed for endometriosis/adenomyosis at our hospital in that period, only one procedure involved SLH (by patient's choice), all others were TLHs. We recorded 4 fistulas (1,3%), with only one needing repeat surgery, and two cases of disease recurrence requiring surgery (0,6%).

In the presented case, ureteral decompression was successful, allowing the ureteral catheter to be removed 4 weeks postoperatively. The patient is followed, showing no evidence of recurrence or digestive/urinary involvement.

Conclusions

Considering controversies in the literature, lacking fairly recent randomised controlled trial (RCT) data comparing both surgical approaches, and limited numbers of cases in our own setting, no clear conclusions can be made, apart from necessary consideration of all aspects (including presence of adenomyosis) at the time of presurgical decision making. From our perspective, we advocate for TLH, as it seems to reduce the need for future surgery. A carefully designed RCT involving both strategies could prove useful for future decision-making.

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First Reported Case of Tubo-Ovarian Abscess in a Patient with Genito-Pelvic Pain/Penetration Disorder: Laparoscopy as a Key to Diagnosis and Treatment

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Background

To present a rare case of tubo-ovarian abscess (TOA) in a patient with genito-pelvic pain/penetration disorder (GPPPD), and to highlight the effectiveness of laparoscopy as a minimally invasive approach in the diagnosis and management of such complex cases where gynaecological examination is limited.

Methods

A 40-year-old woman (G5P3A2) presented to the emergency department with acute abdominal pain and vomiting for 12 hours. She refused vaginal examination and transvaginal ultrasonography due to a prior diagnosis of GPPPD. Her history included hypothyroidism, three caesarean deliveries, and a T-Copper IUD insertion under general anaesthesia three years prior. Physical exam showed tachycardia (HR: 120 bpm), while imaging (pelvic ultrasound and contrast-enhanced CT) revealed a 65 mm abscess-like lesion in the right adnexal region, suspicious for perforated appendicitis. Laboratory findings were notable for elevated CRP (346 mg/L), procalcitonin (34.7 µg/L), and hypoalbuminemia (28.4 g/L). The general surgery team performed an emergency diagnostic laparoscopy.

Results

Intraoperative findings included purulent intra-abdominal fluid, hydropic bilateral fallopian tubes, uterine adhesions, and spontaneous drainage from the right ovarian fossa. The IUD was removed, two drains were placed, and cultures were collected. The patient was transferred to the gynaecology ward and started on IV imipenem. Due to persistent fever and stable high CRP levels by postoperative day 4, vancomycin and metronidazole were added. On day 7, due to inadequate clinical response, a second laparoscopy was performed, during which bilateral salpingectomy and abscess excision were conducted. Appendectomy was not indicated. The patient was discharged on postoperative day 8 with a 14-day course of oral antibiotics.

The initial delay in diagnosis was attributed to the patient's refusal of a gynaecologic examination due to GPPPD. Laparoscopy enabled accurate diagnosis, source control, and organ preservation with minimal morbidity. Following second-look surgery and antibiotic therapy, the patient recovered without complications.

Conclusions

This case underscores the importance of individualized, multidisciplinary management in patients with GPPPD who present with acute abdominal pain. The coexistence of GPPPD and TOA has not been previously reported. In such patients, non-invasive imaging and minimally invasive surgical

approaches such as laparoscopy are critical for diagnosis and treatment. For women with completed fertility, tubal ligation may be a contraceptive consideration, while condoms should be prioritized for infection prevention.

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Laparoscopic pelvic lymphadenectomy in early-stage endometrial cancer: a surgical video demonstration

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Background

Pelvic lymphadenectomy plays a vital role in the surgical staging of early-stage endometrial cancer. It provides essential information for prognosis and guides adjuvant therapy decisions. Laparoscopic approaches are increasingly favoured due to reduced morbidity and improved recovery, while maintaining oncologic safety.

Methods

We present a surgical video of a laparoscopic pelvic lymphadenectomy in a patient with clinical stage I endometrioid endometrial carcinoma. After laparoscopic entry and abdominal exploration, bilateral pelvic lymphadenectomy was performed. Dissection included systematic removal of lymphatic tissue from the external iliac, internal iliac, and obturator nodal basins. The retroperitoneal space was carefully developed, with clear identification and preservation of anatomical landmarks such as the external iliac vessels and obturator nerve. An advanced energy device was used throughout the procedure to ensure haemostasis and minimize thermal spread.

Results

The lymph node dissection was completed successfully with minimal blood loss. Lymph node packets were removed en bloc and sent for histopathological evaluation. No intraoperative or postoperative complications were encountered. The patient had an uneventful recovery.

Conclusions

This case demonstrates the feasibility, safety, and technical considerations of laparoscopic pelvic lymphadenectomy in early-stage endometrial cancer. The use of laparoscopy provides enhanced visualization, effective dissection, and reduced surgical morbidity. This approach supports the growing role of minimally invasive surgery as a standard of care for surgical staging in appropriately selected patients with endometrial cancer.

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Challenging Total Laparoscopic Hysterectomy in a Patient with Dense Pelvic Adhesions

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Background

Laparoscopic hysterectomy has lower rates of blood transfusion, wound infection, venous thromboembolism, and incisional hernia compared to abdominal hysterectomy. However, it has a higher rate of vaginal cuff dehiscence. Laparoscopic hysterectomy is associated with less postoperative pain, shorter hospital stay, and faster recovery. This method provides better quality of life and body image improvements in the early postoperative period. Additionally, laparoscopic hysterectomy yields more favourable outcomes in terms of sexual function compared to abdominal hysterectomy.

Methods

We presented a total laparoscopic hysterectomy case in a patient with history of previous pelvic infection and surgery.

Results

A 52-year-old female patient presented with abnormal uterine bleeding. From her history, it was learned that she did not respond to medical treatment and had a history of myomectomy and pelvic infection. Total laparoscopic hysterectomy and bilateral salpingo-oophorectomy were recommended and performed. The final pathology revealed no significant findings other than adenomyosis.

Conclusions

We wanted to present a video case report of a total laparoscopic hysterectomy performed on a patient with a history of pelvic surgery and infection, resulting in a highly adhesive pelvis and a surgically challenging case.

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A rare case of vulvar endometrioma

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Background

Endometriosis is a prevalent gynaecological disorder affecting up to 10% of reproductive-aged women, typically involving pelvic structures. Extra pelvic manifestations are rare, with vulvar endometrioma representing an exceptionally uncommon form often leading to delayed diagnosis and suboptimal management. We aim to highlight the clinical features, diagnostic pitfalls and therapeutic surgical management of vulvar endometrioma.

Methods

We report the case of a 34-year-old woman presenting with a vulvar mass located lateral to the clitoris. The mass had been present for several years and was associated with cyclical pain, particularly during menstruation. Her medical history included four vaginal deliveries, complicated by perineal tears and previous surgical excision of a vaginal cyst.

Pelvic ultrasound revealed a mass resembling an endometrioma, measuring 32.5 × 35.4 × 27 mm, displacing the ureter without evidence of infiltration. Magnetic resonance imaging (MRI) confirmed the presence of mass with a haemorrhagic content consistent with an extra pelvic endometriotic lesion. Surgical excision of the vulvar endometrioma was indicated. Initial aspiration of the lesion's contents was followed by infiltration with an ethanol 96% and methylene blue solution. Complete excision of the cyst wall was not feasible due to its deep extension; therefore, only a partial resection was achieved.

Results

At the follow-up, the patient reported complete resolution of her cyclical pain. No recurrence of the vulvar mass was observed clinically. The surgical site had healed well, and no postoperative complications were noted.

Conclusions

Vulvar endometrioma is a rare but important differential diagnosis in women presenting with vulvar masses and cyclic pain. Increased awareness is essential for early diagnosis and appropriate management. While surgical excision remains the primary treatment, hormonal therapy may be considered to decrease the size of large lesions before surgery or to prevent recurrence. Given the paucity of data, further studies are required to better characterize its pathogenesis and optimal treatment strategies.

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Laparoscopic staging surgery in an elderly endometrial cancer patient with a history of gastric perforation and colon cancer surgery

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Background

Staging surgery is critical in the treatment of endometrial cancer. Considering the morbidity, minimally invasive approaches provide great advantages in surgical interventions. This video shows laparoscopic staging surgery in an elderly endometrial cancer patient who has had previous abdominal surgery.

A 78-year-old patient who had 4 normal deliveries applied to the outpatient clinic due to postmenopausal bleeding. She had a history of surgery due to gastric perforation. The patient had a history of surgery and chemoradiotherapy due to colon cancer 7 years ago. The patient, whose endometrial biopsy result was serous endometrial cancer, was planned to undergo laparoscopic staging surgery since there was no distant metastasis.

Methods

During laparoscopic observation, the small bowel segments were densely adherent due to previous gastric perforation and colon cancer. The adhesions were opened with sharp dissections. The pelvis was found to be completely adherent. The retroperitoneal spaces were opened. Type B radical hysterectomy and bilateral salpingo-oophorectomy were performed. Right pelvic and left pelvic lymphadenectomy were then performed. The retroperitoneal space was also found to be quite adherent. Since the patient was 78 years old, had previously undergone gastric perforation and colon cancer surgery, and had extensive retroperitoneal adhesions, para-aortic lymphadenectomy was not performed because the morbidity would outweigh the benefit. The omentum was partially resected. The tissues were removed from the vagina, and then the vaginal cuff was sutured intracorporeally as a continuous stump with 0 vicryl suture. No early complications were observed.

Results

The patient was discharged on the 3rd postoperative day without any complications. Pathology result: Endometrial serous carcinoma, the tumor was seen in an area of approximately 1 cm in diameter and did not exceed 1/2 of the myometrium. No lymphovascular invasion was observed. Cervix, serosal side of the uterus, ovary, tube uterine and parametrial soft tissue are intact. No pelvic lymph node metastasis was observed. The patient refused chemotherapy and brachytherapy was completed.

Conclusions

Gynaecologic oncology surgical procedures should be performed with the most minimally invasive technique, taking into account morbidities. A minimally invasive approach can minimize the risk of wound infection, accelerate patient recovery, and allow early initiation of adjuvant therapy.

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Navigating the Ureter in Total Laparoscopic Hysterectomy for Intraligamentary Myoma

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Background

This video presentation explores the surgical implications of navigating the ureter during total laparoscopic hysterectomy (TLH) in cases of intraligamentary myomas, focusing on the necessity of precise ureteral dissection to minimize complications.

Methods

Intraligamentary myomas pose a significant surgical challenge due to their proximity to the ureter, increasing the risk of ureteral injury during hysterectomy. This video presentation demonstrates a total laparoscopic hysterectomy (TLH) in a patient with an intraligamentary myoma, emphasizing the critical role of meticulous ureteral dissection to prevent iatrogenic injury. Preoperative imaging confirmed ureteral displacement due to myoma compression, necessitating careful identification and mobilization of the ureter throughout the surgical field. The laparoscopic approach, with optical magnification and precise dissection techniques, allows safe navigation of the ureter while ensuring complete myoma resection and hysterectomy. This video highlights the advantages of minimally invasive surgery, including reduced blood loss, fewer postoperative complications, and faster recovery compared to open procedures.

Results

The procedure was completed successfully in 105 minutes without intraoperative or postoperative complications. Haemoglobin drop was 1.3 g/dL, and no blood transfusion was required. The patient recovered well and was discharged on postoperative day 1, demonstrating the feasibility and safety of the minimally invasive approach in managing intraligamentary myomas with ureteral involvement.

Conclusions

Total laparoscopic hysterectomy for intraligamentary myoma requires precise ureteral identification and dissection to minimize the risk of iatrogenic injury. This case highlights the feasibility and safety of a minimally invasive approach in complex anatomical scenarios, demonstrating favourable operative outcomes with minimal blood loss and early postoperative recovery.

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Uterine-Ovarian Ligament Shortening: Minimally invasive approach to prevent recurrent ovarian torsion in pediatrics

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Background

Ovarian torsion is a rare but serious condition, typically associated with adnexal masses, and more frequently observed in adolescents and young women. It is notably uncommon in prepubescent children. Recurrent episodes of torsion can threaten ovarian viability, impair future fertility and necessitating repeated surgical interventions. In this context, a surgical technique involving the shortening of the uterine-ovarian ligament has been proposed as a method to prevent future torsion by enhancing ovarian stability. This video demonstrates the laparoscopic approach of bilateral uterine-ovarian ligament shortening in a six-year-old girl with a history of multiple detorsion surgeries.

Methods

The patient, a young girl with a six-year history, had undergone several laparoscopic detorsions for ovarian torsion (once bilaterally and twice on the left side). Clinical examination revealed absence of precocious puberty and imaging confirmed recurrent torsion episodes without significant masses. The surgical procedure was performed under general anaesthesia via a minimally invasive laparoscopic approach (5 mm umbilical trocar and two additional 5 mm ports). Both ovaries appeared enlarged but with normal consistency and no focal lesions. The ligamentous anatomy was visualized, revealing elongated utero-ovarian ligaments with increased laxity, especially on the right side. The surgical technique involved suturing the ligament onto itself from the proximity of the isthmus to the ovarian attachment points using non absorbable sutures, thereby effectively shortening and tightening the ligament bilaterally.

Results

The laparoscopic procedure was completed successfully without intraoperative complications. Postoperative recovery was uneventful, and immediate stabilization of the ovaries was achieved. The ligament shortening aims to reduce the risk of future torsion episodes, thus preserving ovarian function and preventing repeated surgical interventions.

Conclusions

Uterine-ovarian ligament shortening via laparoscopy appears to be a safe and effective technique for preventing recurrent ovarian torsion, especially in young children where preserving ovarian tissue is critical. Given the rarity of torsion in this age group, this minimally invasive strategy offers a promising approach to long-term ovarian preservation.

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Laparoscopic Burch Colposuspension Tips and Recommendations

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Background

Introduction: Burch surgery has become frequently used in gynaecology because of the mesh complications nowadays. In this case, we present a patient who underwent laparoscopic Burch colposuspension and right salpingo-oophorectomy.

Case: A 43-year-old woman (G3P3) was admitted to our clinic with pelvic pain. On examination, the uterus was normal, and a 5 cm endometrioma was detected on the right ovary. The left ovary appeared normal. Laparoscopic right salpingo-oophorectomy and Burch colposuspension were planned.

Methods

Surgical Procedure: Under general anaesthesia, in lithotomy position, three 5 mm instrument ports and one 10 mm camera port were inserted. First, a right salpingo-oophorectomy was performed. Then, the Burch colposuspension procedure was started.

Using harmonic, bilateral dissection was made into the space of Retzius. Cooper's ligaments and ureters were visualized. The ureters were suspended from the endopelvic fascia to Cooper's ligament bilaterally with Ethibond sutures. Cystoscopy revealed no pathology. The peritoneum was closed with 2/0 Vicryl sutures.

Results

Results: The postoperative course was uneventful. The urinary catheter was removed on postoperative day 2. The patient reported no difficulty in urination, no urinary retention, and no increased frequency. She was discharged on postoperative day 4.

Conclusions

Suggestions and Tips:

- The first suture should be placed at the mid-urethral level, just below the balloon of the Foley catheter.
- The second suture should be placed at the level of the urethrovesical junction, 2 cm lateral to the bladder and also lateral to the first suture.
- The bladder neck should be adequately retracted during suture placement.
- When tying the sutures, a 2 cm "bridge" suture distance should be maintained and should not be fully tightened.

<https://player.vimeo.com/video/1090259437?autoplay=1>

Laparoscopic sacrocolpopexy for post-hysterectomy prolapse

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Background

Vaginal vault prolapse following hysterectomy presents a significant surgical challenge, with laparoscopic sacrocolpopexy emerging as the gold standard treatment due to its superior anatomical restoration and minimal invasiveness. This procedure requires meticulous attention to pelvic anatomy and systematic technique to achieve optimal outcomes while minimizing complications.

Methods

62-year-old patient who underwent vaginal hysterectomy with cystocele repair 4 months ago for total uterine prolapse and presented to our clinic with complaints of vaginal cuff prolapse. Physical examination revealed total prolapse of the vaginal cuff. The decision was made to perform laparoscopic sacrocolpopexy.

Results

Throughout the procedure, the vaginal vault is first identified with the aid of a vaginal retractor and deperitonised, followed by dissection of the bladder and rectum. Subsequently, the sacral promontory is identified and deperitonised to expose the anterior longitudinal ligament. A tunnel is created from the right lateral aspect of the sacrum toward the right side of the vaginal apex. The Y-shaped mesh is fixed to the anterior and posterior vaginal walls using polypropylene sutures. The free end of the mesh is then passed through the tunnel, and after adjusting the tension, it is fixed to the anterior longitudinal ligament at the level of the promontory using a tucker. Finally, all opened peritoneal surfaces are re-closed and the procedure is completed.

Conclusions

Performing the procedure laparoscopically also has several additional advantages. These include less postoperative pain, the possibility of faster hospital discharge, and better cosmetic results due to minimal scarring.

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Repair of Vesicovaginal Fistula with Martius Flap in a Patient with Recurrent Cervical Cancer

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Background

Radical surgical interventions and radiotherapy applied in the treatment of cervical cancer pose a risk in terms of vesicovaginal fistula formation. Surgical repair is the basic method that provides a permanent solution in the treatment of vesicovaginal fistula. Transvaginal repair technique is recommended as the first choice in selected cases due to its minimal invasiveness, low morbidity rate and high success rate.

Methods

A 45-year-old female patient who had three normal births and one caesarean section underwent radical hysterectomy and chemoradiotherapy at an external centre with the diagnosis of cervical squamous cell carcinoma. Gynaecological examination revealed changes in the vagina due to radiotherapy and was stenotic. PET-CT: The soft tissue lesion observed in the inferior left iliac bifurcation in the previous imaging and could be a hypermetabolic metastatic lymph node is progressing in size and metabolic activity in the current study. The left ureter trace remained within the lesion and dilatation was observed along the left ureter in the current study. Ureteral invasion was considered. In the current study, no fatty plane was observed between the soft tissue lesion and the left posterolateral wall of the bladder. MRI: No recurrence was detected in the operation area. However, a heterogeneous T1A hypointense, T2A hyperintense and diffusion-limited solid lesion of approximately 4.5x3x3 cm was observed adjacent to the left iliac vascular structures (metastatic lymph node). The fat planes between the defined lesion and the bladder were erased and asymmetrical thickening developed in the bladder wall at this level (bladder invasion). The patient underwent left pelvic lymphadenectomy, left distal ureterectomy, left partial cystectomy, ureteroneocystostomy and bilateral double J stent application. Pathology: The ureter surgical margin is intact, the area marked as adjacent areas to the rectum is intact. The tumour was evaluated as having invaded the bladder muscle layer. No tumour was observed in the bladder mucosa and ureter mucosa. Postoperative follow-up CT after 3 months: There is an appearance of contrast in both collecting systems and the bladder lumen, and the current contrast shows linear extension towards the vagina region. (end of the fistula)

Results

The vesicovaginal fistula site was identified and resected. Primary closure of the fistula was then performed with layered sutures. A Martius flap was prepared and placed vaginally under the bladder. The procedure was completed by repair of the vaginal mucosa.

Conclusions

Fistulas that develop after cervical cancer surgery are complex complications that seriously affect the quality of life of patients. Early diagnosis, selection of appropriate surgical techniques and a multidisciplinary approach increase the chance of success in fistula repair. The advantages of the

transvaginal approach, such as its minimally invasive nature, short hospital stay and low complication rates, make this method a preferred option, especially for small, medium-sized, well-defined fistulas.

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Laparoscopic management of a paracervical fibroma

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Background

Fibromas are benign fibrous tumours of connective tissue and are common among women irrespectively their age. The present case is about a patient G3P2 who presented in our outpatient department with abdominal pain located at the lower abdominal section. TVS revealed a mass at the right lateral paracervical region. Therefore, a laparoscopic procedure was opted.

Methods

A four-port laparoscopy was performed. After the initial inspection of the peritoneal cavity, surrounding tissues were removed in order to reveal the exact position of ectopic gestational sac that was lying on the anterior left side of the previous CS scar, in close proximity to the uterine vessels.

Using bipolar and monopolar diathermy and laparoscopic scissors, the ectopic sac was detached from the anterior uterine wall. In the sequel, the scar was removed and its remain cavity was enclosed by a single layer of interrupted extra-corporeal stitches and reconstruction of the anatomy was achieved.

A running intra-corporeal stitch was used to approximate the edges of uterovesical fold. Final inspection of the peritoneal cavity and an extended control of haemostasis were performed

Results

The patient was discharged the 1st day post-operatively and had uneventful recovery.

A follow up ultrasound was performed 2 months post-operatively and no pathological findings were detected.

Conclusions

Laparoscopic excision of paracervical fibromas is safe and valid alternative to laparotomy and has excellent postoperative results.

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da vinci single port. Set-up

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Background

Robotic surgery has been developed widely in gynaecology. Several platforms are available in the market and most of them offer a multiport approach. Surgical procedures should be standardised to offer a reproducible technique and a safer surgery to our patients. New technologies offer the challenge of performing an optimal technique while we need to adapt to this technology. We present our technical initial experience with the new da Vinci's single port robot.

Methods

We are showing our initial experience in a tertiary university hospital, Hospital Sant Pau, in Barcelona with the new da Vinci's single port platform. We are showing a step-by-step standardised approach for a simpler and optimal set-up of the robot.

Results

After our initial experience of more than 25 procedures in 2 months including gynaecology oncology procedures and benign gynaecology procedures, including hysterectomy and bilateral adnexectomy with sentinel lymph node dissection, extraperitoneal paraaortic lymphadenectomy, hysterectomies for benign conditions, annexectomy and omentectomy in border-line tumours and myomectomy, we are showing how to organise for an optimal set-up of the robot.

Conclusions

Considering our initial experience, da Vinci's single port platform, allows to perform most of the surgical techniques that can be done in a minimally invasive approach with the advantage of a abdominal incision smaller than 3 cm and the possibility to access 360° in the abdominal cavity.

<https://player.vimeo.com/video/1090265846?autoplay=1>

Endoscopy Within an Endoscopy: Pioneering Enhanced Recovery with Same-Day Discharge After Laparoscopic Colposuspension

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Background

Laparoscopic colposuspension is regaining favour as an effective, mesh-free treatment for stress urinary incontinence (SUI). Our centre has developed a refined, minimally invasive transperitoneal approach that not only preserves surgical efficacy but also enables same-day discharge through early catheter removal, marking a significant evolution in enhanced recovery for urogynaecology.

Methods

In this video, we demonstrate how using "endoscopy within an endoscopy" technique—utilizing direct optical entry and a meticulous dissection method that avoids unnecessary bladder manipulation. Key anatomical landmarks, including the ileopectineal ligament and vaginal wall at the bladder neck, are safely exposed and elevated using extracorporeal Ethibond sutures. A routine cystoscopy confirms ureteric integrity.

Results

We present data from a retrospective cohort of 54 patients who underwent this technique between 2014 and 2023. Over time, our catheter removal protocol shifted from next-day removal to immediate post-op removal on the table. The average catheter removal time was 8.3 hours, and 75% had their catheters removed within 4–12 hours in this initial cohort. Early removal was not associated with increased urinary retention or need for re-catheterisation. This has now led to a change in routine practice – all women have their catheter removed in theatre following laparoscopic colposuspension. Notably, we found a strong correlation between earlier catheter removal and reduced hospital stay ($p < 0.001$). The average post-op ICIQ-UI score improved from 16.5 to 6.1, reflecting significant symptomatic relief.

Conclusions

This video highlights not just the technical steps of a safe, reproducible laparoscopic colposuspension, but also a culture shift toward enhanced recovery. Immediate catheter removal and same-day discharge are not only feasible, they may be the future standard of care for appropriately selected patients.

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Laparoscopic Segmental Rectosigmoid Resection for severe endometriosis

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Background

The treatment of rectovaginal endometriosis is primarily indicated for symptomatic relief, with medical therapy serving as the first-line intervention. Surgical consideration arises when patients demonstrate inadequate response to conservative management. The surgical approach is determined by two key anatomical factors: (1) lesion size, where nodules exceeding 3 cm may require either shaving excision, discoid resection, or segmental bowel resection, and (2) proximity to the anal verge, with lesions within 5 cm often necessitating temporary stoma formation due to the technical challenges of low rectal anastomosis. This stratified approach ensures tailored intervention based on disease characteristics while balancing procedural morbidity.

Methods

A 34-year-old G1P1 patient with medically refractory pelvic pain and intestinal symptoms underwent laparoscopic surgery after imaging revealed deep infiltrating endometriosis (30 mm ovarian endometrioma, bilateral hydrosalpinges, and bowel involvement) with preserved ovarian reserve (AMH: 2.67 ng/mL). The surgical approach was guided by lesion characteristics (size >3 cm, subserosal bowel infiltration) and fertility goals, with preoperative counselling on potential stoma formation.

Results

The patient successfully underwent laparoscopic segmental rectosigmoid resection without complications. She was discharged on postoperative day 3 with significant symptomatic improvement (VAS pain score reduction from 8 to 2).

Conclusions

Laparoscopic segmental resection is an effective option for severe bowel endometriosis when medical therapy fails, offering marked symptom relief while addressing fertility preservation. Multidisciplinary planning and patient counselling are essential for optimal outcomes.

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Large Uterus, Minimal Access: V-NOTES Hysterectomy in an Obese Patient

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Background

Hysterectomy remains one of the most frequently performed procedures in gynaecologic surgery. While the vaginal route is often preferred due to its minimally invasive nature and favourable recovery profile, it has technical limitations especially in cases involving large uteri or limited exposure. Vaginal Natural Orifice Transluminal Endoscopic Surgery (V-NOTES) offers a promising alternative, combining the advantages of vaginal access with the enhanced visualization and precision of laparoscopy. This hybrid approach has increasingly gained traction since the early 2000s as a feasible option for selected cases that would otherwise require abdominal intervention.

Methods

Here, we present a case of a 46-year-old obese patient who successfully underwent V-NOTES hysterectomy, despite the challenges posed by a markedly enlarged uterus. The patient, gravida 3, para 2, with a BMI of 30, with two prior vaginal deliveries and one abortion, presented with menometrorrhagia. Transvaginal ultrasonography revealed an enlarged uterus with multiple fibroids, measuring approximately 153 × 172 × 95 mm, extending toward the umbilicus. V-NOTES total hysterectomy was scheduled.

Under general anaesthesia, the patient was placed in lithotomy position. Following antiseptic preparation, a circumferential cervical incision was made. Two tenacula provided traction. A 3-cm posterior colpotomy was created, and the anterior vaginal wall was dissected to enter the vesicouterine space. Both anterior and posterior peritoneal cavities were accessed using sharp and blunt dissection.

The uterosacral and cardinal ligaments were bilaterally coagulated and transected using a 5-mm LigaSure. The Alexis retractor was inserted, with the inner ring placed into the peritoneal cavity and the outer ring rolled for retraction. The patient was then placed in Trendelenburg.

A 5-mm, 30-degree laparoscope enabled clear visualization. The uterine arteries were coagulated and divided bilaterally, followed by stepwise transection of the round, broad, and infundibulopelvic ligaments. The bulky uterus was transvaginally morcellated to prevent trauma. The Alexis retractor was then removed, and the colpotomy was closed with an absorbable running suture.

Operative time was 85 minutes with minimal blood loss and no complications. The patient was discharged the next day.

Results

This case demonstrates that V-NOTES is a feasible and safe approach even in obese patients with large uteri. The use of laparoscopy allowed for easy identification and secure ligation of the uterine arteries, ensuring adequate haemostasis. The absence of abdominal incisions reduces the risk of wound related complications, which is particularly advantageous in patients with elevated BMI. The combination of direct vaginal access with laparoscopic control enabled successful management of a

challenging case, avoiding abdominal morbidity and yielding excellent cosmetic and functional outcomes.

Conclusions

With appropriate patient selection and surgical expertise, V-NOTES offers a scarless, minimally invasive alternative even in complex cases, maintaining both the functional advantages of laparoscopy and the cosmetic and recovery benefits of the vaginal route.

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Seeing is Healing: Precision Removal of Retained Products via Hysteroscopy

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Background

Retained products of conception (RPOC) are a common complication following miscarriage, abortion, or delivery, often resulting in abnormal uterine bleeding, infection, and potential long-term fertility issues. Traditional blind curettage has been the standard treatment but carries risks such as incomplete evacuation and endometrial trauma. Hysteroscopic management offers a more precise alternative, allowing direct visualization and targeted removal of retained tissue. This video demonstrates a standardized hysteroscopic technique for the safe and effective management of RPOC.

Methods

This educational video presents a real-time hysteroscopic procedure performed under general anesthesia. Preoperative preparation included the administration of **misoprostol** for cervical priming and **norethisterone** to induce withdrawal bleeding and improve visibility. Prophylactic antibiotics were also given to reduce infection risk. The procedure involved cervical dilation, insertion of a hysteroscope into the uterine cavity, and systematic inspection to identify retained tissue. A mechanical hysteroscopic morcellator was used to resect and aspirate the products under continuous direct visualization. Key steps, such as optimizing uterine distension, avoiding blind movements, and minimizing damage to healthy endometrium, are emphasized throughout the demonstration.

Results

The procedure resulted in complete removal of visible RPOC, confirmed by visual inspection of a clear uterine cavity at the end of the surgery. There were no intraoperative complications such as uterine perforation or excessive bleeding. The patient was discharged the same day and reported no adverse symptoms during postoperative follow-up. Normal menstruation resumed within four weeks. The video illustrates not only the technique itself but also the safety and efficiency associated with the hysteroscopic approach.

Conclusions

Hysteroscopic removal of RPOC is a safe, effective, and fertility-preserving alternative to blind curettage. This technique allows for thorough evaluation and targeted resection of intrauterine tissue, reducing the risk of complications and improving clinical outcomes. The presented video serves as a visual guide for gynaecologic surgeons and trainees aiming to adopt or refine hysteroscopic skills in managing RPOC.

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Preoperative Selective Uterine Artery Embolization Combined with Intraoperative Haemostatic Techniques to Minimize Blood Loss in Laparoscopic Myomectomy: A Case Series

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Background

Laparoscopic myomectomy remains the preferred uterine-sparing surgical option for women with symptomatic uterine fibroids. However, intraoperative blood loss poses a significant challenge, especially in cases involving large or multiple fibroids. This case series evaluates the efficacy of combining preoperative selective uterine artery embolization (UAE) with intraoperative haemostatic measures, including vasopressin injection, to minimize intraoperative blood loss.

Methods

We retrospectively reviewed a case series of 7 patients who underwent laparoscopic myomectomy /Hysterectomy at our institution over the last 2 years. All patients had large (>5 cm) or multiple fibroids and received preoperative selective UAE before the surgery. Intraoperatively, diluted Argypressin was injected locally into the myometrium surrounding the fibroids to further control bleeding. Estimated blood loss, operative time, perioperative complications, and need for blood transfusion were recorded and analysed.

Results

The combination of preoperative UAE and intraoperative Argypressin use resulted in a marked reduction in intraoperative blood loss, with a mean estimated blood loss of 100 mL. One of the patients required postoperative blood transfusion. The average operative time was 90 minutes. There were no major perioperative complications, and all patients were discharged within 48 hours postoperatively.

Conclusions

Preoperative selective uterine artery embolization, when combined with intraoperative Argypressin injection, appears to be a safe and effective strategy to significantly reduce blood loss during laparoscopic/open myomectomy and hysterectomy in patients with large or multiple fibroids. This combined approach may enhance surgical safety and preserve the minimally invasive nature of the procedure without compromising uterine integrity.

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Reperitonization in intra-abdominal mesh erosion following laparoscopic sacrocolpopexy.

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Background

Laparoscopic sacrocolpopexy is an effective surgical treatment for pelvic organ prolapse (POP), but mesh-related complications, including erosion, may occur. This case highlights the importance of adequate reperitonisation in preventing mesh exposure and ensuring long-term success.

Methods

A 38-year-old woman with a history of total hysterectomy underwent laparoscopic sacrocolpopexy for symptomatic POP. During surgery, the vaginal cuff was reopened and re-sutured due to dense scarring. One month later, asymptomatic transvaginal mesh erosion was identified. Surgical excision of the exposed mesh and transvaginal closure of the defect were performed, followed by local oestrogen therapy for three months.

Results

The patient experienced full resolution of both POP symptoms and pelvic pain. Two years after the intervention, she remains asymptomatic and fully functional in daily life. Surgical review of the original procedure indicated that minimal mesh coverage may have contributed to erosion, emphasizing the need for complete peritoneal closure.

Conclusions

Proper reperitonisation is a critical component of laparoscopic sacrocolpopexy. Using an adequate amount of tissue to ensure full mesh coverage can reduce the risk of erosion and improve long-term outcomes. This case underscores the importance of meticulous surgical technique, especially in patients with prior pelvic surgery or extensive scarring.

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Out with the Bone: A Video Demonstration of MyoSure Hysteroscopic Extraction of fetal bone

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Background

Retained foetal bone fragments in the uterine cavity are a rare but significant cause of abnormal uterine bleeding, secondary infertility, and pelvic pain. These fragments may remain following mid-trimester miscarriage, termination, or incomplete delivery. Hysteroscopic removal allows direct visualization and targeted extraction, avoiding blind instrumentation. This video demonstrates the use of the MyoSure system for safe and effective hysteroscopic extraction of intrauterine fetal bone.

Methods

This procedural video presents the hysteroscopic removal of foetal bone using the MyoSure tissue removal system under general anaesthesia. The patient presented with persistent intermenstrual bleeding and a history of second-trimester termination. Transvaginal ultrasound revealed echogenic material within the endometrial cavity, suggestive of calcified retained tissue. Preoperative preparation included the administration of **misoprostol** for cervical softening and **norethisterone** to synchronize endometrial shedding. Prophylactic antibiotics were administered. Under continuous visual guidance, the MyoSure device was introduced into the uterine cavity through a rigid hysteroscope. Bone fragments were identified as bright white; sharply margined structures embedded within the endometrium and were carefully extracted using the MyoSure morcellator. The procedure emphasized precision, minimal trauma to the surrounding tissue, and complete removal.

Results

Multiple bone fragments were successfully extracted without intraoperative complications. The average operative time was 5 minutes. The uterine cavity was visually confirmed to be free of retained material by the end of the procedure. The patient reported resolution of symptoms and resumed normal menstrual cycles within one month. Follow-up ultrasound confirmed a clear cavity. The video clearly demonstrates the identification, approach, and removal of fetal bone using MyoSure, with commentary on tips for maximizing safety and visualization.

Conclusions

The MyoSure system provides a safe and effective means of removing retained fetal bone under hysteroscopic guidance. It allows for accurate tissue differentiation and targeted extraction with minimal endometrial trauma. This video serves as a practical and instructional guide for clinicians seeking to manage complex intrauterine retained material, particularly calcified fetal remains, using a minimally invasive approach.

<https://player.vimeo.com/video/1090293848?autoplay=1>

<https://esge.covr.be/cmdocumentmanagement/conferencemanager/documents/api/getdocument/15006/cmabstsms/0000165550/b60cf28113de9aee63fe4dbc75471b06dda96eb867b88395808c90900cc4e60d>

Beyond the bulk: Successful laparoscopic hysterectomy for large uterus without port migration

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Background

Laparoscopic hysterectomy for uterus significantly enlarged to the level of the promontorium or beyond poses considerable technical challenges. These often lead surgeons to alter standard port placements (e.g., supraumbilical, Lee- Huang point) to achieve adequate surgical access. This presentation explores techniques to manage such cases effectively while adhering to conventional umbilical port configurations.

Methods

This presentation demonstrates a surgical approach for total laparoscopic hysterectomy (TLH), with or without bilateral salpingo-oophorectomy (BSO), in patients with very large uteri, maintaining conventional umbilical camera port placement. The technique systematically employs five key strategies: (1) consistent umbilical port siting irrespective of uterine size; (2) meticulous, step-by-step dissection—starting with the round ligament, developing the utero-vesical fold, and incising lateral peritoneal attachments, performed unilaterally then bilaterally—to progressively create operative space; (3) effective intraoperative uterine manipulation for optimal exposure; (4) strategic use of 30 or 45-degree laparoscopes to navigate around the uterine bulk; and (5) systematic and secure vascular pedicle management. Two illustrative cases (a 55-year-old with Stage IB endometrial cancer; a 48-year-old with a 12 cm symptomatic myoma) are presented. Informed consents were taken before surgery for using operation video without disclosing any personal detail.

Results

The application of these five strategies enabled the successful completion of TLH/BSO in the presented cases of significantly enlarged uteri without requiring any modification of the standard umbilical port location or the use of specialized trocars. The described techniques facilitated adequate visualization, progressive uterine mobilization, and safe dissection and ligation of vascular pedicles. The video demonstrates the feasibility of this approach and the key surgical steps that contribute to a successful outcome.

Conclusions

Conventional laparoscopic hysterectomy for uteri reaching the promontorium can be performed safely and effectively without altering standard umbilical port placement. By systematically employing strategies that emphasize meticulous dissection to create space, effective uterine manipulation, optimal visualization, and secure hemostasis, surgeons can confidently manage these challenging cases while adhering to familiar laparoscopic setups.

<https://player.vimeo.com/video/1090386518?autoplay=1>

Laparoscopic Hysterectomy for Deep Endometriosis: A Case Presentation and Surgical Approach

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Background

Endometriosis, characterized by ectopic endometrial tissue, is a gynaecological disorder causing chronic pelvic pain, infertility, and dysmenorrhea. In deep infiltrative endometriosis (DIE), pain severity often correlates with lesion depth and volume. Surgical intervention becomes imperative when medical therapy fails. Laparoscopic hysterectomy is an effective treatment for pain relief, particularly in patients with completed fertility, persistent symptoms, or concurrent indications (e.g., fibroids). While ovarian preservation remains debated, recent evidence supports bilateral salpingo-oophorectomy (BSO) in cases with extensive adnexal disease or high recurrence risk.

Methods

A 43-year-old multiparous woman (G3P2) presented with refractory chronic pelvic pain. After failed medical therapy, laparoscopic total hysterectomy with BSO was performed.

Results

Postoperatively, the patient reported significant pain reduction (declining VAS scores).

Conclusions

Laparoscopic hysterectomy is highly effective for pain management in DIE patients with completed fertility. BSO may further reduce recurrence risk, particularly in older patients or those with severe adnexal involvement. Individualized decision-making balancing recurrence risk and menopause-related consequences is crucial.

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Laparoscopic adhesiolysis for infertility

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Background

This film presents a diagnostic and operative laparoscopy performed for secondary infertility in a patient with a scarred uterus and a history of pelvic inflammatory disease. The objective is to highlight the role of minimally invasive surgery in evaluating and managing tubal and pelvic factors contributing to infertility, particularly in complex cases with prior uterine surgery.

Methods

The procedure is performed under general anaesthesia with the patient in a dorsal lithotomy position. A careful laparoscopic entry is made due to the presence of a scarred uterus.

Results

Upon inspection, significant pelvic adhesions are identified, likely contributing to the infertility. A methylene blue dye test ("blue dye test") is then carried out to assess tubal patency. Even though the test confirms bilateral tubal permeability we preordered An adhesiolysis which is meticulously performed to restore the normal anatomy of the pelvis and free the fallopian tubes. The ovaries are examined and found to be morphologically normal. Throughout the procedure, special attention is given to minimizing trauma to reproductive structures and the use of coagulation was limited.

Conclusions

Laparoscopy remains a key tool in the assessment and treatment of secondary infertility, especially in patients with previous pelvic surgery or ectopic pregnancy. It allows for direct visualization of pelvic anatomy, therapeutic intervention such as adhesiolysis, and functional testing like the blue dye test. This case illustrates the value of laparoscopy in identifying correctable causes of infertility and guiding further management

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Laparoscopic management of a borderline tumour during pregnancy

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Background

This educational film presents the surgical technique of left adnexectomy by laparoscopy performed for a borderline ovarian tumour in a pregnant woman at 20 weeks of gestation. The objective is to demonstrate the feasibility and safety of minimally invasive management of adnexal masses during pregnancy, while preserving maternal and foetal health.

Methods

The procedure is carried out under general anaesthesia with the patient in a dorsal supine position, slightly tilted to the left to avoid uterine compression of major vessels.

Results

A laparoscopic approach is used, employing an open-entry technique for the first trocar to minimize the risk of uterine injury. Pneumoperitoneum is maintained at a low pressure (10–12 mmHg) to ensure foetal safety. We choose to introduce 2 trocars in the left flank and left iliac fossa to manipulate the mass. The uterus is clearly visualized, and the enlarged left ovary is gently mobilized. we performed initially an exploration of the entire peritoneal cavity with peritoneal biopsies, omental biopsies, and peritoneal cytology. Then, The left adnexa is carefully dissected using atraumatic instruments. The utero-ovarian ligament, fallopian tube, and infundibulo pelvic ligament are isolated and coagulated with bipolar energy before being sectioned. Special care is taken to minimize manipulation of the gravid uterus. The specimen is retrieved using an endobag to avoid tumour spillage. Hemostasis is verified, and the procedure is completed without complications.

Conclusions

Laparoscopic adnexectomy for borderline ovarian tumour during the second trimester of pregnancy is a safe and effective approach when performed with appropriate precautions. This film underlines the importance of multidisciplinary planning and precise surgical technique in managing adnexal masses during pregnancy.

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laparoscopic promontofixation

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Background

Laparoscopic promontofixation is a minimally invasive surgical technique employed to correct pelvic organ prolapse, particularly apical prolapse. This procedure provides durable support and is associated with reduced postoperative morbidity compared to open surgery.

Methods

The technique involves several key steps. First, general anaesthesia is administered, and laparoscopic access is achieved via a transumbilical trocar and additional accessory ports

Results

The peritoneum over the sacral promontory is carefully dissected to expose the anterior longitudinal ligament. After mobilization of the rectovaginal and vesicovaginal spaces, synthetic mesh is anchored to the anterior and/or posterior vaginal wall using non-absorbable sutures. The mesh is then secured to the sacral promontory, providing firm apical support. Finally, the peritoneum is closed over the mesh to prevent bowel adhesions.

Conclusions

This approach offers the benefits of faster recovery, lower blood loss, and smaller incisions. Long-term studies demonstrate high success rates and patient satisfaction, making laparoscopic promontofixation a gold-standard procedure for uterovaginal and vault prolapse.

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Pushing the Boundaries: Standardized vNOTES Hysterectomy for a 1200g Uterus with Same-Day Discharge

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Background

Vaginal Natural Orifice Transluminal Endoscopic Surgery (vNOTES) is a promising minimally invasive alternative to laparoscopic or open hysterectomy. While its use in routine cases is well established, its application in large uteri remains underreported due to anatomical and technical challenges. We will demonstrate the feasibility of a standardized 10-step (METHODICAL) vNOTES hysterectomy technique in a patient with a 1200g uterus, highlighting rapid recovery and same-day discharge.

Methods

A standardized 10-step approach was used:

1. M - Mobilise the uterus and assess descent: Plan for uterine immobility
2. E - Evaluate exposure
3. T – Transect Vessels and Ligaments
4. H – Haemostasis and Blood Management: be meticulous with bleeding control
5. O – Orient to Organs (Ureters/Bladder): The ureters run close to the pelvic sidewalls and can be displaced by a big uterus.
6. D – Displace Bowel and Uterus: Use packs and positioning to optimize the view.
7. I – Infundibulopelvic (IP) Ligament Management: Carefully seal the ovarian pedicles.
8. C – Crossing Instruments & Cautious Technique: Adapt to single-port constraints.
9. A – Achieve Specimen Extraction (Bagging): Plan removal early with adequate size bag
10. L – Last Steps and checks (Morcellation Safety): shield the bladder and bowel from your sharp instruments.

Results

The operation was completed without complications or need for conversion. Blood loss was minimal. Despite the uterine size, anatomical exposure and manoeuvrability were maintained. The Enseal bipolar device provided effective vessel sealing. Manual morcellation was performed safely using the Exise technique inside a specimen retrieval bag to minimize tissue spread. The patient was discharged three hours postoperatively with a pain score of 0 on the Visual Analogue Scale (VAS) at the time of discharge. No readmissions or postoperative complications occurred.

Conclusions

This case demonstrates that with a structured and reproducible approach, vNOTES hysterectomy for very large uteri ($\geq 1200\text{g}$) is both safe and highly feasible. The use of advanced bipolar instrumentation, effective containment morcellation, and enhanced visualization supports the technique's utility. Most significantly, this approach enabled a same-day discharge with minimal postoperative pain, reinforcing the value of vNOTES in complex surgical cases.

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Pelvic anatomy and laparoscopic hysterectomy

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Background

Laparoscopic hysterectomy is a minimally invasive surgical procedure for the removal of the uterus, offering benefits such as reduced postoperative pain and quicker recovery compared to open surgery. A thorough understanding of pelvic anatomy is essential to ensure the safety and efficacy of this procedure.

Methods

Such films are designed to support medical education by offering detailed demonstrations of the laparoscopic approach to hysterectomy, emphasizing the identification and preservation of critical anatomical landmarks

Results

The procedure typically begins with the identification and division of the round ligaments, followed by the opening of the anterior and posterior leaves of the broad ligament to access the retroperitoneal space. This allows for the identification and lateralization of the ureters, minimizing the risk of injury during uterine artery ligation

This approach allows for the development of the paravesical and pararectal spaces, critical for safe dissection and avoidance of injury to adjacent structures.

the hysterectomy steps are

1. Division of the Round Ligaments: Initiates access to the retroperitoneal space.
2. Ligation and Division of the Infundibulopelvic Ligaments: Secures the ovarian vessels, allowing for the removal of the ovaries.
3. Mobilization of the Bladder: Dissection of the vesicouterine peritoneal fold to separate the bladder from the uterus.
4. Ligation of the Uterine Arteries: Identifying and securing the uterine arteries to control blood supply.
5. Circumferential Incision of the Vagina: Allows for the removal of the uterus and cervix.
6. Closure of the Vaginal Cuff: Suturing the vaginal incision to complete the procedure

Conclusions

a comprehensive knowledge of laparoscopic pelvic anatomy, including the vascular, urinary, and fascial structures, is imperative for performing a safe and effective simple hysterectomy. Meticulous surgical technique, guided by anatomical landmarks, minimizes the risk of complications and enhances patient outcomes.

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laparoscopic hysterectomy for gestational trophoblastic disease

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Background

Gestational trophoblastic disease (GTD) refers to a group of uterine disorders that include premalignant conditions as well as malignant forms known as gestational trophoblastic neoplasia (GTN). Chemotherapy remains the standard first-line treatment for GTN. However, for some patients whose reproductive goals are fulfilled, a primary hysterectomy may be chosen as an alternative to chemotherapy in cases of non-metastatic GTN and can lead to shorter treatment durations and fewer chemotherapy cycles.

To date, minimally invasive hysterectomy (MIH) for GTD has only been described in case reports. The aim of this film is to demonstrate the surgical technique of MIH in a patient with chemotherapy-resistant GTD and a scarred abdomen.

Methods

The patient is placed in the dorsal supine position under general anaesthesia. The surgeon stands on the left side with two assistants managing uterine manipulation. Uterine cannulation is performed using a specialized manipulator screwed into the cervix after dilation. Four trocars are introduced: one 10–12 mm umbilical trocar and three 5 mm trocars placed strategically.

Results

The round ligament is exposed and cut after mobilization, while the uterus is maintained cranially and anteriorly. The anterior peritoneum of the broad ligament is opened to the vesicouterine pouch, and vascular structures are coagulated. Dissection continues carefully to isolate the adnexa and protect the ureter. Uterine pedicles are coagulated and dissected progressively. The vagina is transected with a monopolar instrument, guided by the cannula valve. The uterus is extracted vaginally, and vaginal suturing is done with absorbable stitches. Pneumoperitoneum is released, and haemostasis and closure complete the procedure.

Conclusions

GTD is rare, and large patient cohorts are hard to establish. Thus, the authors advocate for multi-institutional and international collaboration to confirm the safety and efficacy of MIH compared to open hysterectomy. Meanwhile, close monitoring of MIH patients remains essential.

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Endoscopic management of OHVIRA syndrome

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Background

OHVIRA syndrome, also known as obstructed hemivagina and ipsilateral renal anomaly, is a rare congenital condition where a woman has a combination of a blocked or partially obstructed vagina and a missing kidney on the same side. Causing structural abnormalities may lead to complications and discomfort. Individuals with Ohvira syndrome need to seek medical attention for proper management and support.

Methods

A 13-year-old girl with lower abdominal pain during menstruation admitted to our department. She had menses from 12 years old, with 4-5 days duration, and every period pain increased. Sonographically on the 18th day of the cycle revealed uterus sizes as 125*62*72mm in anteflexion, the body of the uterus was bicornuate, M-echo-2-3 mm, in the secretory phase, the cavity was extended, with hyperechogenic content, one servix also included hyperechogenic content, hematocolpos. The tubes and ovaries were revealed without pathology. There wasn't any liquid in Douglas's cavity. The kidney on the right side was undetected. The patient was referred to the hospital. Laboratory test results showed normal admission. The decision was to perform laparoscopic and colposhysteroscopic exploration.

Steps of the surgery (Video)

1. Left palmer point Veres's needle puncture. Introduction of 5 trocars.
2. Initial inspection. Uterus didelphys and bilateral hypogenesis of uterine appendages were observed.
3. Under laparoscopic inspection performed colp hysteroscopy, one cervix, two uterus cavities with one tubal ostium for each other and transverse-longitudinal septum of the vagina was detected.
4. Dissection of vaginal septum performed with electroresection.
5. Evacuation of accumulated blood executed after removing the obstructing structures of the vaginal septum.
6. Lavage.
7. Removal of trocars

Postoperative period was led with antibiotics and infusional therapy.

Results

Treatment for Ohvira syndrome typically involves addressing symptoms and complications to improve quality of life and may require a combination of medical and surgical management

Conclusions

Surgical Intervention manages to remove the obstructing structures such as the vaginal septum or the uterine remnants is the main treatment for OHVIRA syndrome.

<https://player.vimeo.com/video/1091648045?autoplay=1>

Unintended ureter damage during advanced laparoscopic surgery during a demonstration workshop

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Background

There is limited evidence regarding the outcomes of laparoscopic surgeries performed during demonstration workshops, including live broadcasts, due to sparse data. However, this remains a significant issue in modern laparoscopy, considering patient safety, ethical concerns, and educational value

Methods

A recorded video of an intraoperative incident demonstrates unintended ureter damage caused by bipolar coagulation during laparoscopic pelvic lymph node dissection, followed by its correction. The complication occurred after complete ureter exposure, which was attributed to a lapse in concentration

Results

Following intraoperative consultation with urologists, the ureter was transected, and an anastomosis was performed over a pre-placed double J stent, completing the planned surgical procedure

Conclusions

As laparoscopy remains the most popular surgical modality today and live demonstrations are integral to training, it is essential to develop specific guidelines to organize these events effectively. Additionally, other educational tools, such as prerecorded videos, merit particular attention. Surgical teams involved in live broadcasts must be prepared for intraoperative complications to manage them appropriately, ensuring patient safety and ethical standards

<https://player.vimeo.com/video/1092358785?autoplay=1>