稿件編號： OE1	**腹腔鏡肌瘤切除手術新方法- Tsutsumi's method** **Tsutsumi's method, a new approach to laparoscopic myomectomy**
臨時收件編號： 2766	梁玉惠[1] 林欣達[1] 賴宗炫[1,2] 國泰綜合醫院
論文發表方式： 口頭報告	Laparoscopic myomectomy (LM) is a minimally invasive procedure with many advantages than abdominal myomectomy in selected patients. Patients experience less pain, less hospital stay and shorter recovery time. However, performing LM in women with large or numerous myomas is likely to be time consuming, particularly since morcellation is usually required. FDA currently estimates that a hidden uterine sarcoma may be present in approximately 1 in 225 to 1 in 580 women undergoing surgery for uterine fibroids based on recent publications. Open (uncontained) morcellation of the uterus and myomas has been scrutinized because of the possible spread of an unsuspected leiomyosarcoma while using a power morcellator during LM. The FDA warns against using laparoscopic power morcellators in gynecologic surgeries to treat patients with suspected or confirmed cancer, and in the majority of women undergoing myomectomy or hysterectomy for uterine fibroids. Recently, Professor Osamu Tsutsumi proposed a modified LM without using morcellator. This method not only avoided morcellation, it is also time efficient for multiple myomas or large myomas and even can be done in patients with adenomyoma. In order for better surgical approach and to avoid the use of morcellation, we did a case series of uterine myomas/adeonmyoma with/without ovarian cyst using Tsutsumi's method LM. Tsutsumi's method LM is better approach for multiple myomas/adenomyoma compare with traditional LM.
論文歸類： 內視鏡	

台灣婦產科醫學會 109 年度年會暨擴大學術研討會

論 文 摘 要

稿件編號： OE2	**膀胱深度浸潤子宮內膜異位症的年輕女性以達文西機械手臂行輸尿管再植入的兩年追蹤報告**
臨時收件編號： 2723	**2 Years Follow up of Robotic Ureteral Re-implantation in a Young Female with Previous Bladder Trigone Deep Infiltration Endometriosis and Review of Urinary Tract Endometriosis** 王孝棻[1] 莊乙真[1] 亞東紀念醫院 1}
論文發表方式： 口頭報告	Study Question: Urinary tract endometriosis is characterized by endometriosis involvement of the urinary tract system and is very rare (1-2%). Patients with deep endometriosis infiltration (DIE) of urinary tract might suffer from disturbing symptoms or signs including dysuria, frequency, hematuria, or even hydronephrosis. Study Design: In our hospital, one young female patient with DIE of bladder trigone with hydronephrosis who was treated with Da Vinci Robotic excision of the mass on the bladder and re-implantation of the ureter on February, 2017. She received the post-operative follow up duration for 30 months. Materials, Settings and Methods: Preoperative data (mode of presentation, diagnosis, imaging), intraoperative surgical video recording, and postoperative follow-up data were recorded. Review of genital-urinary tract DIE literatures was done. Main Results: The symptoms were free during the 30-month follow up duration. Although MRI image taken in this June (2019) still shows the presence of DIE into bladder, her symptoms are not compatible with the image, neither pyelonephritis nor cystitis occurs. Conclusion: Surgical intervention of urinary tract DIE could reduce symptoms and signs effectively. However, the traditional laparoscopic setting demands high surgical techniques. Therefore, it is very feasible for Gynecologist to use Da Vinci Robotic to treat DIE of bladder trigone.
論文歸類： 內視鏡	

台灣婦產科醫學會 109 年度年會暨擴大學術研討會

論 文 摘 要

稿件編號：
OE3

臨時收件編號：
2801

子宮鏡內膜切除手術及宮內投藥 Mirena 合併治療肌腺症之效果

Insertion of Mirena after Endometrial Resection in Patients with Adenomyosis Mirena after TCRE: to do or not to do ?

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國防醫學院三軍總醫院婦產部[1] 康寧醫療財團法人康寧醫院婦產科[2] 國防醫學院公衛研究所[3]

論文發表方式：
口頭報告

論文歸類：
內視鏡

Abstract

Study Objective:

To evaluate the efficacy of insertion of Mirena, a levonorgestrel-releasing intrauterine device, after hysteroscopic endometrial resection for treatment of menorrhagia and dysmenorrhea caused by adenomyosis.

Design:

a retrospective clinical observational study.

Patients: Thirty-six women

Intervention:

After hysteroscopic endometrial resection, Mirena inserted immediately after the procedure.

Measurements and Main Results:

A total of thirty-six women was included in this retrospective clinical observation study during a two years period from 2015 through 2016. Follow up examination at least 2 years after the combined procedures.

The mean age of these patients was 42 years (31-51), with follow–up intervals ranging from 25 to 54 months. The mean follow–up interval was 40 months.

Twenty-two of the 36 patients (61 %) were satisfied with the results. Three patients (3 %) were partially satisfied. Eight (31 %) was dissatisfied with the results of the procedure included : 1 woman weight gain, 2 with recurrent vaginal infection, 1 low abdominal discomfort, and 1 allergic reaction, only 4 (11%) with failed treatment 2 underwent hysterectomy and 2 expulsion of mirena were failed improvement of clinical symptoms. Total clinical improvement was in 32 of 36 (89%). Amenorrhea was achieved in 6 of 36 women (16%)of patients, with 19 of 36 (52%) experiencing lighter bleeding. Both reported some improvement in dysmenorrhea but had been hoping for more improvement.

Conclusion:

Insertion of Mirena after endometrial resection is easy to perform and effective treatment for menorrhagia caused by adenomyosis and has very few adverse effects.

稿件編號：
OE4

臨時收件編號：
3409

比較手動與幫浦給水進行子宮鏡手術: 一個隨機對照試驗

Manual versus Pump Infusion of Distending Media for Hysteroscopic Procedures: A Randomized Controlled Trial

陳奐樺 [1] 林鶴雄 [1, 2] 蕭聖謀 [1, 2, 3]
亞東紀念醫院 [1] 臺大醫院 [2] 元智大學生物科技與工程研究所 [3]

論文發表方式：
口頭報告

論文歸類：
內視鏡

Objective:
To compare perioperative outcomes and changes in electrolytes after hysteroscopic procedures between the manual infusion (MI) and the pump infusion (PI) methods for distending media infusion.

Material and Methods:
One hundred consecutive women who had hysteroscopic procedures between December 2013 and February 2017 were recruited and randomly allocated to either MI or PI group. The primary outcome was to compare the volume of distending media used. The secondary outcome was to compare
the postoperative changes in serum electrolyte levels and blood osmolarity between groups.

Results:
Baseline characteristics were similar between the groups. The PI group was associated with an increased volume of infused fluid and collected fluid compared with the MI group. Almost all serum electrolyte levels differed significantly between the baseline and postoperative values in both groups； however, no significant differences were noted between the groups. The change in potassium level was positively correlated with the volume of fluid deficit (Spearman’s rho = 0.25, P=0.02), whereas the change in calcium level was negatively correlated with the volume of fluid deficit (Spearman’s rho = -0.26, P=0.03).

Conclusion:
The MI method was associated with a reduced infused fluid, compared with the PI method. With no between-group differences in the changes of the other perioperative parameters and electrolytes, the MI methods can be a good alternative for delivering distending media for less complex hysteroscopic procedures.

稿件編號： OE5	**腹腔鏡 alien-egg 術式治療子宮肌腺症之成效及預後探討** **Efficacy and outcomes of laparoscopic adenomyomectomy using alien-egg method for uterine adenomyosis**
臨時收件編號： 3350	李艾倫[1] 郭信宏[2] 李奇龍[2] 王錦榮[2] 顏志峰[2] 黃詩穎[1] 林芝卉[1] 高川琪[1] 基隆長庚紀念醫院[1],林口長庚紀念醫院[2]
論文發表方式： 口頭報告	Objective: The comprehensive treatment for severe adenomyosis is hysterectomy. However, for patients wishing to preserve their uterus, adenomyomectomy has been considered the priority. Current surgical skills included partial or complete adenomyomectomy without or without flaps overlapping by open or laparoscopic approach. Lacking of tactile feedback and higher learning curve, laparoscopic adenomyomectomy is assumed to be more difficult and have more residual tissue than open method. Alien-egg laparoscopic adenomyomectomy excise tumor with crossed direction and maximize the exposure of the tumor. In this talk, we aimed to introduce this skill and review the clinical outcome in four years. Materials and Methods: Laparoscopic adenomyomectomy using the alien-egg method (n=20) to treat adenomyosis. Visual analog scale (VAS), menstrual amount, serum CA125 levels, and uterine volume were analyzed. Results: From October 2015 to September 2019, there were 20 cases of laparoscopic-assisted adenomyomectomy at Chang Gung Memorial Hospital. The VAS scores, dysmenorrhea, hypermenorrhea, serum CA125 levels, and uterine volume at 6 months after surgery significantly reduced ($P < 0.05$). In addition, mean blood loss was less than 200 ml and the mean operative time was less than 2 hours. No recurrence was noted. Conclusions: Laparoscopic adenomyomectomy using the alien method may be an effective technique to treat uterine adenomyosis.
論文歸類： 內視鏡	

稿件編號：
OE6

臨時收件編號：
2832

經陰道自然孔內視鏡子宮切除手術之回溯性研究

Hysterectomy by transvaginal natural orifice transluminal endoscopic surgery (NOTES) : a prospective study

林玉珊[1] 吳凱筠[1]
林口長庚紀念醫院[1]

論文發表方式：
口頭報告

論文歸類：
內視鏡

STUDY OBJECTIVE:
To evaluate the feasibility and safety of hysterectomy in benign disease using transvaginal natural orifice transluminal endoscopic surgery (NOTES) and compare the surgical outcome between different uterine weights.
DESIGN:
Prospective observational study.
SETTING:
Tertiary referral medical center.
PATIENTS:
From May 2012 to May 2016, consecutive patients who were scheduled to undergo laparoscopic hysterectomy and without virginity, history of tubo-ovarian abscess or severe endometriosis, or suspected pelvic inflammation or cul-de-sac obliteration were included.
INTERVENTION:
Total hysterectomy via transvaginal NOTES.
MEASUREMENTS AND MAIN RESULTS:
The study included 277 patients, with mean (SEM) age 48.0 (5.9) years and body mass index 24.2 (3.8). Transvaginal NOTES was successfully performed in 275 patients (100%). Two patients underwent concurrent adhesiolysis, and 58 underwent adnexal procedures. Mean (SEM) uterine weight was 447 (344.8) g； in 67 patients (24.4%), uterine weight was >500 g, and in 17 (6.2%) it was >1000 g. Operative time was 87.1 (39.3) minutes, with blood loss of 242.0 (296.3) mL. In one patient there was intraoperative bladder injury, in 5 patients there was immeidately postoperative internal bleeding, and in another 2 there was postoperative pelvic peritonitis. There were 2 patients of conversion to conventional LAVH due to bladder adhesion. The mean operative time was significantly longer when the uterine weight increased. And the mean estimated blood loss was significant lower when uterine weight less then 500 g when compared with the groups 500-999 g and ≥ 1000g.
Comparisons to previous study:
There was similar in terms of age, parity, BMI or uterine weight. The proportion of conversion to conventional laparoscopy in current data was lower when compared with previous study (2/277, 0.72% and 7/137, 5.1%).
CONCLUSION:
Transvaginal NOTES is a feasible technique for performance of hysterectomy and can be used in procedures that are difficult to complete via conventional vaginal surgery because posterior colpotomy is achievable. Transvaginal NOTES can be used to accomplish some difficult procedures in conventional vaginal surgeries such as enlarged uterus, undescensus, and adnexal surgery. In addition, NOTES LAVH provides safety entry and alternative approach in patients with multiple upper abdominal surgeries.

稿件編號：
OE7

臨時收件編號：
3380

婦科腹腔鏡手術後尿滯留之發生率及風險因子分析

Postoperative urine retention in women after gynecologic laparoscopic surgeries: incidence and risk analysis

邱俐珺 顏志峰
林口長庚醫院婦產部

論文發表方式：
口頭報告

論文歸類：
內視鏡

Objective: Patients undergoing non-hysterectomy laparoscopic surgeries, such as those of adnexal surgeries or myomectomy, were empirically not involving urination functions and refrained from postoperative Foley-catheter indwelling in our institution routinely for decades. However, we encountered a severe case of acute urine retention. The objective of this study is to study the incidence of postoperative urine retention after laparoscopic surgeries.

Materials and Methods: Patients undergoing laparoscopic adnexal surgery and/or myomectomy for benign diseases since June 10, 2019 by a single surgeon were routinely checked for residual urine (RU) by bladder scan after their first postoperative self-voiding were included in this retrospective study. Normal urinary function was defined as post-voiding RU < 100mL. Abnormal RU < 150 mL would undergo repeated scans after self-voiding till normal data was achieved. Intermittent catheterization program (ICP) would be performed on those patients with RU > 150 mL, while patients with repeated RU > 150 mL would be indwelled a Foley catheter for 24 hours.

Results: We included and reviewed data from 93 cases since Jun. 15 till Nov. 12, 2019. At least 20 patients experienced transient incomplete voiding and needed 2 or more bladder scan to achieve normal urination function, and at least 4 of the patients experienced urine retention which resulted in Foley catheter indwelling. About 70% of these patients had undergone adnexal surgeries, and 30 % were myomectomies who seems quite irrelevant to the bladder function.

Conclusions: Incidence of transient incomplete voiding seems high immediately after benign, non-hysterectomy laparoscopic surgeries, and in which, the patients of urinary retention seems to be more than expectation. A strict confirmation of complete voiding is suggested to be a mandatory procedure of postoperative care after the first self-voiding even though the laparoscopy could seem quite irrelevant to the bladder function.

稿件編號： OE8	**比較絞碎器子宮鏡手術及傳統電環子宮鏡手術切除粘膜下肌瘤和息肉之不同** **Differences in surgical status, complications, and endometrial influence in contrasting**
臨時收件編號： 2848	林大欽[1] 黃閔暄[1] 朱益志[1] 關龍錦[1] 郭宗正[1] 台南郭綜合醫院 婦產部
論文發表方式： 口頭報告	Abstract Study Question:
論文歸類： 內視鏡	The aim is to study the difference of surgical status and endometrium recovery between the hysteroscopic morcellator (HM) and traditional electrical hysteroscopic resection (EHR) in the removal of intrauterine myomas and polyps. Study Design, Size and Duration: We performed a retrospective study on 88 women (the majority coming from fertility clinics) undergoing operative hysteroscopy via HM with Truclear morcellator and traditional EHR in Kuo General Hospital from January 1, 2017 to August 31, 2019. Materials, Settings and Methods: We collected data on installation and operating times, irrigation fluid usage, fluid eficit, as well as peri- and postoperative complications. If they were cases of infertility, we performed subsequent endometrial assessments within three months with sonography or second-look hysteroscopy. Main Result: In nine patients undergoing myomectomy with the HM, the mean installation time was 9.7 min, mean operating time 25.8 min, mean irrigation fluid usage 1050ml, and median fluid deficit 440 mL. None of them were converted to EHR and one of them experienced water-overloading with pulmonary edema. In comparison, for eight patients having undergone traditional EHR for myomectomy, the mean installation time was 15.4 min, mean operating time 58.5 min, mean irrigation fluid usage 2850ml, and median fluid deficit 730 mL. One of them experienced water intoxication and needed further management. In 32 patients for polypectomy via HM, the mean installation was 8.2 min and mean operating time was 12.6 min. Only three of them needed cervical dilator for HM insertion. Available subsequent mean endometrium thickness at the end-proliferation phase within three months was 8.8 mm in the 21 cases of HM usage. In 39 patients for polypectomy with the EHR, mean installation was 13.8 min and mean operating time was 40.8 min. Cervical dilator was used in 32 cases for EHR insertion. Available subsequent mean endometrium thickness at the end proliferation phase within three months was 7.3 mm. Conclusion: When compared to EHR, HM for removal of myomas or polyps appears to have had shorter operation time and less irrigation fluid usage. The endometrium recovery in infertile cases seemed to be better in HM in the aspect of endometrium thickness.

稿件編號： OE9	**經陰道自然孔腹腔鏡全子宮切除術** **Transvaginal NOTES for total hysterectomy**
臨時收件編號： 2896	林佳昀 李伊菱 吳昱靜 黃寬慧 龔福財 莊斐琪 高雄長庚紀念醫院婦產部
論文發表方式： 口頭報告	Objective The aim of this study was to demonstrate the feasibility, safety and clinical outcomes of a total hysterectomy performed by transvaginal natural orifice transluminal endoscopic surgery (vNOTES). Materials and Methods From April, 2016 through August, 2019, sixty-seven transvaginal NOTES hysterectomies (TVNHs) were performed by a single surgeon (Chuang FC). Fourty-five transvaginal NOTES hysterectomies were performed by laparoscopy and the other twenty-two transvaginal NOTES hysterectomies were performed by robotic assisted laparoscopy. Intraoperative and postoperative surgical outcomes were measured. Results No conversion to traditional laparoscopy or laparotomy was necessary in any of the 67 patients who underwent a TVNH. The mean laparoscopy postoperative hospital stay was 2.7 ± 0.9 days and was 3.4± 3.0 days in robotic assisted group. In the laparoscopy group, the mean (±SD) operation time was 130.9 ± 54 mins； the mean (±SD) uterine size was 14.4 ± 3.3 weeks. And in the robotic group, the mean (±SD) operation time was 152.9 ± 56.5 mins； the mean (±SD) uterine size was 14.1 ±2.9 weeks. There were no any abdominal organs damages in both groups. Post-operative pain score were both very low in two groups. Conclusion Transvaginal NOTES hysterectomies (TVNHs) is a safe, cosmetic and feasible procedure for treatment of uterine benign disease, even in large uterus and obesity patients. Transvaginal NOTES approach not only avoids abdominal wall wounds and trocar-related complications but also decrease the hospital stay and post-operative pain.
論文歸類： 內視鏡	

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論 文 摘 要

稿件編號：
OE10

臨時收件編號：
2856

子宮肌腺症之海扶刀治療-高醫治療經驗分享

High-Intensity Focused Ultrasound (HIFU) Treatment For Adenomyosis: A Short-Term Treatment Outcome In Kaohsiung Medical University Hospital

鄭丞傑[1] 張至婷[1] 盧紫曦[2] 劉奕吟[3] 龍震宇[3] 莊蕙瑜[1] 林冠伶[2] 詹德富[1]
高雄醫學大學附設醫院[1] 高雄市立大同醫院(委託高雄醫學大學經營)[2] 高雄市立小港醫院(委託高雄醫學大學經營)[3]

論文發表方式：
口頭報告

論文歸類：
內視鏡

Objective:
To investigate the efficacy and safety of ultrasound guided high-intensity focused ultrasound (USgHIFU) ablation treatment for adenomyosis.

Methods:
From April 2015 to April 2019, a total of 203 patients with adenomyosis were included for treatment using Haifu JC Focused Ultrasound Tumor Therapeutic System (operating transducer frequency: 0.8MHz, 300-400W/cm2) in Kaohsiung Medical University Hospital, Taiwan. The treatment status, treatment effect and complications were recorded. Volume change of uterus and adenomyotic lesion were calculated with MRI before and 3 months after treatment. CA-125 before and 3 months after treatment was also compared. Clinical symptoms improvement evaluation was based on clinical visit, visual analogue scale (VAS), and health-related quality of life scores using the Uterine Fibroid Symptom and Quality of Life questionnaires (UFS-QOL).

Results:
Among 203 patients, 135 had pure adenomyosis and 68 had combined with uterine fibroids. Of them, 67.98% were diffuse type and 32.02% were focal type adenomyosis. Mean age was 41.4±5.3 years old. The mean sonication time was 689.2±424.7 seconds. The average exposure energy was 262850.6 ± 187310.1 J. The size of uterus and adenomyotic lesion decreased 26.48% and 44.59% respectively at 3 months after treatment (both P

Conclusions:
Ultrasound-guided HIFU was found to be an effective technique for treating both focal and diffuse adenomyotic lesions, shrinkage of lesion size, and to alleviate the symptoms. Major complication is very rare.

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論 文 摘 要

稿件編號： V1	**腹腔鏡子宮畸形手術在先天泌尿生殖器異常疾病的應用** **Laparoscopic metroplasty: a reconstructive treatment for patients with unicornuate uterus with non-communicating rudimentary horn**
臨時收件編號： 2692	顏志峰[1] 白欣玉[1] 闕河晏[1] 黃惠鈺[2] 林口長庚紀念醫院婦產部[1], 台北長庚紀念醫院婦產部[2]
論文發表方式： 影片展示	Objective: To demonstrate laparoscopic metroplasty on a patient with Mullerian anomaly type II. Materials and methods: A 13-year-old, G0, menarche at 9-years-old, female, with no previous underlying diseases had been suffering from severe dysmenorrhea during her recent menstrual cycles. Initial assessment at a primary care center suggested presence of uterus didelphys with a left ovarian endometrioma. Transrectal 3-D sonography, hysteroscope, and MRI scans performed in our hospital were consistent for a normal right hemi-uterus, with direct connection to its vagina； an isolated left hemi-uterus with hematometra and no connection to left hemi-vagina； left ovarian multiloculated cystic mass； and, absence of left kidney. We use a narrated video featuring the diagnostic tests and surgical management of this clinical case. Laparoscopic adhesiolysis, enucleation of left ovarian tumor, and uterine metroplasty were performed. Results: Her intra- and post-operative courses were uncomplicated and was discharged under stable condition on postoperative day two. She currently has regular menstrual cycles, with no recurrences of dysmenorrhea or ovarian endometrioma. The previously enlargedleft hemi-uterus gradually returned to the size similar to the normal right hemi-uterus. At the 2-year postoperative follow-up, MRI scans showed an anteverted, symmetrical-sized uterus while hysteroscopic exam revealed a single uterine cavity with a small fundal septum. Conclusion: Instead of the widely applied hemi-hysterectomy, we propose using laparoscopic metroplasty to surgically correct the obstructed non-communicating didelphys. By reconstructing the uterus, this method offers an effective way to attain symptomatic relief and restoration of normal anatomy.
論文歸類： 內視鏡	

台灣婦產科醫學會 109 年度年會暨擴大學術研討會

論 文 摘 要

稿件編號： V2	**如何在複雜的深部浸潤型子宮內膜異位症手術中辨認，保留，甚或修復 hypogastric nerve**
臨時收件編號： 3360	**Identification, preserving, and repairing the hypogastric nerve during complex DIE surgery**
	孫仲賢 方俊能 陳瑞華 王元勇 莊國泰 四季台安醫院
論文發表方式： 影片展示	Introduction: DIE (deep infiltrating endometriosis) surgery remains the most challenging laparoscopic pelvic surgeries, not only because of the distorted anatomy by dense adhesion, and also because of the loss of normal dissection plane from severe tissue fibrosis. For those patients with DIE lesions involving posterior compartment (i.e., uterosacral ligament, USL) or even pelvic sidewall, the hypogastric nerves are almost always being entrapped or being infiltrated. Transection of the hypogastric nerve may induce loss of bladder proprioception, urinary incontinence, and unstable bladder. Materials & Methods: Several surgical videos of complex DIE surgery involving hypogastric nerves were collected and edited. Results: In this video, firstly we will briefly introduce the important pelvic neuroanatomy under laparoscopic view. Secondly, we will demonstrate a case with posterior DIE involving bilateral USL, incorporating the left hypogastric nerve and left inferior hypogastric plexus (pelvic plexus) that makes nerve-sparing DIE surgery almost impossible. Despite maximal effort to restore the normal anatomy, during the adhesiolysis and DIE radical excision process, left hypogastric nerve was inadvertently transected, but later was re-approximated after finishing DIE excision. Conclusions: In cases with advanced DIE, proper identification of the retroperitoneal structures (including ureter, vessels, and nerves) is important. All surgeons should have the knowledge of the important pelvic neuroanatomy, so as to make maximal effort to preserve the hypogastric nerves during complex DIE surgery.
論文歸類： 內視鏡	

稿件編號： V3 臨時收件編號： 3365	**利用陰道 Deaver retractor 進行精準安全且便宜的全腹腔鏡子宮全切除手術** **Safe and cheap way to perform total laparoscopic hysterectomy (TLH) without colpotomizer: the usage of vagina Deaver retractor** 方俊能 孫仲賢 王元勇 陳曼玲 莊國泰 四季台安醫院
論文發表方式： 影片展示	Introduction: Comparing to laparoscopic-assisted vaginal hysterectomy (LAVH), total laparoscopic hysterectomy (TLH) has the benefit of total visual control with less risk of bladder, rectum, or ureter injury during parametrium dissection/resection, and colpotomy. With the aid of the commercialized colpotomizer, the ureter can be effectively displaced laterally, and the entry point of colpotomy can be easily recognized. Thus the TLH procedure can be quite straight forward and easy. However, commercialized colpotomizer will increase the cost, and is not always affordable by patient. To perform colpotomy without colpotomizer, the most common way is to use a “sponge on stick”, grabbing a piece of gauze, push up the anterior vagina wall, so as to expose the anterior vagina fornix for colpotomy. However, with this method, the vagina cut length is difficult to control, and sometimes surgeon may cut into the cervix. We developed a different way for exposing the exact anterior fornix area for colpotomy by way of using the vagina Deaver retractor. Materials and methods: Several surgical videos of TLH were collected, reviewed, and edited. Results: In this video, we will demonstrate our technique of TLH without commercial colpotomizer. TLH was performed as ordinary method, with the aid of uterine manipulator, and with retroperitoneal monitoring. Uterine arteries were secured. After well-exposure of the vesico-vagina space, and identification of the ureter path, parametrium area were cut with energy device. Then we removed the uterine probe, while retaining the teneculum grasping on anterior cervix, and put in a vagina Deaver retractor, sliding along the anterior vagina wall until approaching the cervix. The exact level of anterior vagina fornix can be easily felt during sliding the Deaver retractor. Anterior vagina fornix were lifted by Deaver and could be easily identified under laparoscope. Anterior colpotomy was then performed with unipolar scissors. Once anterior colpotomy was performed, the vagina Deaver retractor and teneculum were removed, and the remaining portion of lateral and posterior fornix can be cut, under direct visual control under laparoscope field. Conclusions: TLH can be easily and safely performed by way of retroperitoneal monitoring of the ureter path, and exact colpotomy with the aid of vagina Deaver retractor, without the need of colpotomizer, thus maintaining the surgical safety and efficiency while saving the cost.
論文歸類： 內視鏡	

台灣婦產科醫學會 109 年度年會暨擴大學術研討會

論　文　摘　要

稿件編號： V4	**陰道鏡輔助腹腔鏡修補剖腹產疤痕憩室** **Combined laparoscopic and hysteroscopic repair of cesarean scar defect**
臨時收件編號： 3370	傅皓聲 張景文 林貝珊 臺北醫學大學附設醫院婦產部
論文發表方式： 影片展示	BACKGROUND: A cesarean scar defect, also known as an isthmocele or cesarean scar diverticulum is the result of incomplete healing of the myometrium in the isthmus after a low transverse uterine incision performed for cesarean section. CASE SUMMARY: A 35-year-old woman with a history of extraperitoneal cesarean section was complained of prolonged postmenstrual spotting(duration 11-14 days) after previous cesarean section. The transvaginal sonography revealed a 13 × 5-mm cesarean scar defect with 3.5mm residual myometrium thickness. Because of desire for childbearing, laparoscopic repair of cesarean scar defect assisted with hysteroscopy was offered. INTERVENTION: The first step of the procedure was the cautious mobilization of the bladder from its adhesions with the site of the previous cesarean scar. In the same time, the cervix of the uterus was dilated using Hegar dilator. The hysteroscopy was performed in patients to further confirm the diagnosis and to visualize the location of the defect. Subsequently, the isthmocele site was identified with the aid of the hysteroscopic light, the defect became translucent. The hysteroscopy was placed into the cervix with the aim of maintaining the continuity between the cervical canal and the uterine cavity. Then, the myometrial repair was performed with the use of a single layer of interrupted 2-0 Vycril sutures. RESULT: The patient was discharged on postoperative day 2. At 2-month follow-up, her menstrual cycles were regular, were approximately 26 days long with a menstrual flow of 5 days' duration and without postmenstrual spotting. CONCLUSION: Using laparoscopy repair of isthmocele is a safe and minimally invasive procedure. However, it is difficult to comfirm the isthmocele edges. Hysteroscopic transillumination enables a better visualization to identify the defect. Therefore, as demonstrated in this case, a laparoscopic approach with hysteroscopy might be considered to be the procedure of choice for the repair of isthmocele.
論文歸類： 內視鏡	

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論 文 摘 要

稿件編號： V5	**自然孔內視鏡全子宮切除術入門十點技巧** **Ten tips of vNOTES hysterectomy for a novice**
臨時收件編號： 2752	魏君卉[1] 何坤達[1] 桂羅利[2] 張裕[2] Tae Joong Kim[3] 柳營奇美醫院婦產部[1] 義大醫院婦產部[2] 南韓三星醫學中心婦產部[3]
論文發表方式： 影片展示	Objective: Ten tips of vNOTES hysterectomy for a novice
論文歸類： 內視鏡	Material & Methods: This 50 y/o female, P2 (VD), suffered from heavy menstrual bleeding and prolonged period for 2 years. Transvaginal ultrasound (TVU) showed an intramural myoma of 5 cm at posterior wall and an endometrial polyp of 2 cm. Pelvic examination revealed uterine prolapse (stage I) and no pelvic adhesion. She has no history of abdominal operation. She was scheduled for vNOTES hysterectomy. Results: The operation time was 90 minutes. Weight of specimen was 162.8g, and blood loss was minimal. There was no operative complication. The patient was discharged in the next morning after operation. The hospitalization was just one day. Ten tips are as follows: 1) pre-operative TVU survey for Cul-de-sac 2) find the cutting junction of anterior and posterior fornix 3) retroperitoneal approaching skill 4) cut uterosacral ligament as early as possible for pulling down the uterus 5) the safe sharp dissection width of vesicocervical ligament 6) tip to set up the wound retractor 7) avoid torsion of wound retractor 8) cervical amputation 9) push the uterus up instead of pulling down and 10) turn the uterus for more operative space. Conclusion: vNOTES hysterectomy has several possible advantages, such as less pain, faster recovery, shorter hospital stays and no scar on the abdomen. The thresholds of NOTEs total hysterectomy can be overcome by 10 tips.

稿件編號：
V6

臨時收件編號：
2889

使用子宮鏡開通流產手術所造成的子宮頸口沾黏

Office Hysteroscopic Recanalization of Internal Cervical Synechiae Caused by Surgical Abortion

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論文發表方式：
影片展示

論文歸類：
內視鏡

Introduction:
Intrauterine synechiae which location can be included uterine cavity, cervical canal and both. Intrauterine synechiae multifactorial with multiple predisposing and cause factors, approximately 90% of cases of severe intrauterine synechiae cause by technique of curettage for pregnancy termination such like missed or incomplete abortion. And surgical abortion usually occurred at the isthmic region of the internal cervical orifice about 12%. Office hysteroscopy can be a good stool to evaluate, diagnosis and treatment the disease.

Case report:
A 39-year-old woman, gravida 7, para 2, abortion 5, presented with amenorrhea since she received suction curettage 5 months ago. Furthermore, she had a history of retained gestational tissue and intrauterine adhesion on 8 years ago. Her ultrasound showed endometrium with 50mm thickness otherwise there was no significant finding. As patient past history and clinical finding suspect internal cervical canal synechiae.

Method:
Hysteroscopy was performed with a 2.8mm rigid hysteroscope (Karl Storz Endoscopy Canada Ltd.). Patients were offered an opportunity to visualize the findings of their internal cervical synechiae and resume uterine cavity on the screen that on the ceiling while during the procedure.

Result：
Using hysteroscopy can identify the severity of the endocervical synechiae and. We can use a hysteroscope's tip to make a gentle dissection under the real-time image. Also, we could use microscissors through the operating port to perform adhesiolysis indeed. The whole procedure's time is short, and the patient denied pain or discomfortable. There was no complication.

Conclusion:
Office hysteroscopy have been worldwide use. Uterine synechiae caused by surgical abortion usually occurred at the isthmic region of the internal cervical orifice, for which the rigid mini-hysteroscopy is an ideal instrument and technique and can effectively manage the situation with minor procedures in the office setting.

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論 文 摘 要

稿件編號： V7	**侵犯至骨盆底部提肛肌神經的罕見深部浸潤型子宮內膜異位症病例** **Encountering levator ani nerve during LSC DIE surgery**
臨時收件編號： 3366	王元勇 孫仲賢 李宜明 陳曼玲 莊國泰 四季台安醫院
論文發表方式： 影片展示	Background: There are many important somatic and autonomic nerves in the pelvic retroperitoneal space. DIE (deep infiltrating endometriosis) lesions frequently involve uterosacral ligament (USL), and then infiltrate to the retroperitoneal structures. Nerve-sparing DIE excision is our surgical goal. Most of us are familiar with the anatomy of hypogastric nerve, pelvic splanchnic nerve, pelvic plexus, and sacral nerve roots. Levator ani nerve originates from S3 to S5, travels just superficial to the levator ani muscles to innervate these muscles. Levator ani nerve is rarely encountered or exposed during our routine laparoscopic DIE surgery. In this video, we will demonstrate a rare case with Rt posterior DIE lesions infiltrating almost the whole USL, involving the levator ani nerve. Methods: Surgical videos were collected and edited. Results: Hidden in the DIE fibrotic complex, it was difficult to directly identify the levator ani nerve. The indirect sign of the nerve entrapment is the levator ani muscle twitching during electrosurgery nearby the nerve. After careful stratification of the USL DIE complex, and careful dissection and exposure of the hypogastric nerve, pelvic splanchnic nerve, and sacral nerve roots, the right levator ani nerve originated from S3 can be identified, and preserved, while taking out all the fibrotic USL DIE lesions. Conclusions: Although rare, levator ani nerve may be involved by DIE lesions. With the anatomical knowledge, it is possible to isolate and preserve the nerve during laparoscopic DIE surgery.
論文歸類： 內視鏡	

稿件編號： V8	**門診子宮鏡在處女病人的應用** **Office hysteroscopy in virgin patients**
臨時收件編號： 3339	陳彥錚 莊乙真 盧信芬 陳珮凌 亞東紀念醫院婦產部
論文發表方式： 影片展示	Objective: Hysteroscopy is a procedure that allows a gynecologist to looks inside the uterus in order to diagnose and treat the cause of abnormal uterine bleeding. The procedure can be either diagnostic or operative. Hysteroscopy is done by using a thin, lighted tube that is inserted into the vagina to examine the cervix and the cavity of the uterus. Generally speaking, a speculum is usually used first for dilating the vagina in order to exam the whole cervix well. However, in those patients who were virgins, most gynecologists will abandon the use of speculum for preventing injuries of the hymen. Nevertheless, many Asian women remain their virginity even till late forty or near fifty. The office hysteroscopy could be utilized as a useful tool for the patients who hope to acquire definite cause of the abnormal bleeding without injury of the hymen. Methods: Here we present our video to show the technique by using Olympus HYF-V flexible, digital hysterovideoscope with 3.8 mm diameter scope for the possible causes of abnormal uterine bleeding in three virgins, aged 25, 36 and 42, with intact hymen. The patients were put on lithotomy position without anesthesia in outpatient settings. The hysteroscope was put slowly through hymen, and the vagina was inflated with distilled water first. The orifice of cervix was searched after inspecting the whole vagina. The flexible hysteroscope was then put into the cervix gently and crossed the endocervix, and then inspecting the orifice of bilateral fallopian tubes. Results: All patients tolerated the whole procedure well without complications. Small submucosal myomas were noted in one patient and endometrial polyps were noted in the other two patients. Conclusions: It is feasible to use flexible hysteroscopy to exam virgin patients with abnormal uterine bleeding, which can not only provide a definite diagnosis but also reserves the virginity for the patients.
論文歸類： 內視鏡	