稿件編號：V1

臨時稿件編號：
0990

論輸尿管分離步驟在手術治療骨盆腔完全沾黏中的必要性
The necessity of the ureterolysis in completely cul-de-sac obliteration

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論文發表方式：
影片展示

論文歸類：
內視鏡

Study Objective:
To demonstrate the necessity of ureterolysis in completely obliterated cul-de-sac patient, that may help surgeon clarify the original anatomy, reduce complication rate of ureter injury and make the excision of deep endometriosis infiltration safer.

Background:
Endometriosis in severe cases lead to deep infiltrating endometriosis with completely obliteration cul-de-sacs in pelvis. This type of cases usually present a challenge for the operating surgeon when performing surgical intervention treatment especially when doing adhesiolysis and endometriosis lesion excision. The complication rate was high owing to the anatomy deformation.

Design:
A stepwise video demonstration of the surgical procedure

Setting:
Linkou Chang Gung Memorial Hospital. 3D Laparoscopy with 10mm main trocar and three 5mm ancillary trocars. Energy device is GYRUS ACMI PKS CUTTING FORCEPS and bipolar forceps.

Intervention:
First of all, recognized the pelvic anatomy and identify the layer and adhesion. Then ureterolysis and dissection of rectovaginal septum was performed to reconstruct the original anatomy. Excision of the endometriosis nodule precisely by energy device. Hemostasis was also done at the same time. Recheck the ureter peristalsis again in the end.

Main Results:
The operation was performed successfully with no intraoperative or postoperative complications. Operative time was 3 hours overall, and blood loss was 50 mL. The pathology report of excision confirmed deep endometriosis. The patient was discharged on postoperation day 3. After 1 months, no late complications was detected. Symptom of dysmenorrhea and constipation reported improved.

Conclusion:
Even in the difficult completely cul-de-sacs obliteration cases, adhesiolysis and excision of endometriosis lesion may be safe and precise when the anatomy and structure was clearly identified. To achieve the most ideal surgical treatment outcome, reconstruct with ureterolysis was necessary.

稿件編號：V2

臨時稿件編號：
0698

成功以兩孔手套系統腹腔鏡子宮次全切手術治療剖腹產疤痕妊娠之個案分享
Using two-port glove system laparoscopic subtotal hysterectomy for Cesarean scar pregnancy

李光晏[1] 張文君[1]
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論文發表方式：
影片展示

論文歸類：
內視鏡

Cesarean section scar pregnancy (CSP) is a kind of rare form of ectopic pregnancy which could be managed expectantly, medically or surgically. The incidence of CSP has been reported as approximately 1:2000 of all pregnancies. [1, 2] Systemic Methotrexate treatment following the same regimen as other non-tubal ectopic pregnancies could be consider if the patient is stable, asymptomatic, with or without fetal cardiac activity, less than 8 weeks' gestation, a gestational sac of less than 2.5 cm and greater than 2mm between the pregnancy and the bladder. [3] Also, surgical treatment including laparotomic, laparoscopic or hysteroscopic surgery could be considered if medicine treatment is not appropriate. [4] Laparoscopic wedge resection of CSP and surrounding lower uterine segment could be considered if CSP are advancing anteriorly toward the abdominal cavity and bladder and less accessible by hysteroscopic approach.[5] However, complications including a conversion to laparotomy and massive hemorrhage were noted. Also, wedge successful rate under CSP with massive active bleeding is still under debate. Reviewing previous reports, laparoscopic subtotal hysterectomy (LASH) was seldom noted as a treatment choice for these patients[3, 5, 6]. We present a successful case whom receiving LASH for CSP after receiving mifepristone for early pregnancy artificial abortion.
A 41-year-old lady (gravida 3, para 2, abortus 1), with 2 times of Cesarean section history, received mifepristone (RU486) 11 weeks before visiting National Taiwan University Hospital (NTUH) at gestational age 5 weeks for artificial abortion. Coexisting symptoms incluled lower abdominal dull pain and vaginal spotting. Pelvic examination showed enlarged uterine corpus with reddish vaginal discharge. Transvaginal sonography showed one 4.6 x 4.7 cm echocomplex lesion at lower anterior segment with prominent flow. Thin myometrium thickness at lesion part (1-2mm) was also noted. Follow up β-HCG within 1 week showed no significant decrease (955 – 955 – 872 mIU/mL). CSP was diagnosed and surgical treatment was decided. However, massive vaginal bleeding with severe lower abdominal pain was noted before the scheduled operation. She was brought to emergency department while her vital sign was stable at triage with microcytic anemia (hemoglobin 9.1 g/dL, mean corpuscular volume 73.6 fL). Transvaginal sonography was compatible to previous finding. Due to exacerbation of symptoms, emergent surgical treatment was decided. We performed two-port glove system LASH with bilateral salpingectomy. The total operation duration was 124 minutes while blood loss was 1500 mL and blood transfusion of pack red blood cell 6U. No complication was noted after the surgery and the patient was discharged on post-operation day 3. The patient returned to OPD 1 month after discharge without complication.

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稿件編號：V3

臨時稿件編號：
0832

借助骨科器械移除石化子宮肌瘤之病例報告

Case report- An ossified leiomyoma removed with the assistance of orthopedic instruments in a laparoscopy surgery

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論文發表方式：
影片展示

論文歸類：
內視鏡

Ossification is an exceedingly rare degenerative change in the uterine leiomyomas and is an example of heterotopic bone formation. Leiomyomas can undergo numerous secondary changes including hyaline degeneration, cystic change, myxoid degeneration, infection, necrosis, calcification and rarely ossification. These secondary changes are mainly due to inadequate blood supply, resulting in replacement of muscle fibers by hyaline material, collagen, calcium, mucopolysaccharides or a combination of these. Since an ossified leiomyoma is rarely seen, we will share an interesting case of an ossified leiomyoma removed by introducing orthopedics instruments.

稿件編號：V4

臨時稿件編號：
0977

以機械手臂輔助恥骨韌帶懸吊術作為骨盆腔脫垂的有效手術選擇：一個醫學中心的案例報告

Robotic Pectopexy as an Effective Surgical Option for Pelvic Or-gan Prolapse: A Definitive Case Presentation from a Medical Center

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論文發表方式：
影片展示

論文歸類：
內視鏡

Introduction
Apical prolapse defines as the descent of the vaginal apex including uterus, cervix, vaginal vault, or vaginal cuff after hysterectomy. In addition to pessaries for mild symptomatic prolapse, surgical interventions contain transvaginal native tissue suture repairs and sacrocolpopexy. However, there's a feasible alternative operative method for apical prolapse: pectopexy that is a procedure of fixing the synthetic mesh ends to the bilateral pectineal ligaments for suspending the descend-ed part.

Objective
This presented case is mainly to display the newly surgical procedure of robotic pectopexy with the assistant of da Vinci Si system with a shorter operation time compared with conventional uro-gynecological surgeries.

Methods
A 57-year-old parous (parity:1102) woman with past history of type II DM, hypertension and breast carcinoma in situ, left post modified radical mastectomy and adjuvant chemotherapy who suffered from dragging sensation due to apical prolapse of uterus (prolapse of uterus, stage III Cx, prolapse of anterior wall, stage II Aa and prolapse of posterior wall, stage II Ap). After discussing with the patient about related risks, benefits and potential complications, surgical intervention of robotic pectopexy and bilateral salpingo-oophorectomy was conducted smoothly.

Results
The patient recovered well after the robotic operation and was discharged 48 hours after sur-gery. Postoperative gynaecologic outpatient department follow up was performed without abnormal finding nor further complication.

Conclusion
Pectopexy surgery is a suitable alternative for the patients with apical prolapse of pelvic organs. Combined with advanced da Vinci surgical system, robotic surgery provides clearer, safer and faster operational process with better outcome and may be considered as an effective clinical technique.

稿件編號：V5

臨時稿件編號：
0847

保守性腹腔鏡手術移除腹膜後之輸卵管旁腫瘤
Conservative laparoscopic method for excision of retroperitoneal para-tubal mass

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論文發表方式：
影片展示

論文歸類：
內視鏡

INTRODUCTION: Retroperitoneal mass is always the surgical challenge during minimally invasive surgery. Due to the unfamiliarity of anatomic structure by general OB/GYN practitioner, tumor rupture and content spillage are frequent. We would like to present this case for demonstrating the surgical skills in retroperitoneal dissection and en-bloc tumor removal.

CASE REPORT: This was a 53-year-old female with a self-palpable right middle abdominal mass, just lateral to umbilicus. Pelvic examination showed a term fetal head in size mass, fixed at right abdominal wall, higher level than ordinary ovarian region. Transvaginal ultrasound showed right adnexal cystic-mass, measuring about 11.48x8.24 cm in size. Tumor markers, including CEA (0.45 ng/mL) and CA199 (16.46 U/mL) were within normal limit but CA125 (97.13 U/mL) was abnormal. Based on her and families' request, laparoscopic cystectomy was planned and carried out. A 11cm right para-tubal cyst which located at the height of right para-colic gutter, with connection to right ovary, with retroperitoneal extension. Retroperitoneal dissection and en-bloc tumor removal without tumor rupture nor spillage of tumor content. The mass was removed inside endobag based on the surgical principle of minimally invasive surgery. Post-operative recovery was uneventful. Final pathology confirmed a benign serous cyst.

CONCLUSION: A retroperitoneal mass should be operated carefully because of the unfamiliarity of anatomy and easily surgical rupture. Practice more always makes perfect surgical outcome.

稿件編號：V6

臨時稿件編號：
0873

以達文西 Xi plus 內視鏡鏡頭行機器人手臂輔助卵巢囊腫切除手術
Robotic enucleation and suture of chocolate cyst with new Da Vinci endoscope plus

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論文發表方式：
影片展示

論文歸類：
內視鏡

The estimated prevalence of endometriosis in Taiwan was 8.9% based on the National Health Insurance Research Database (NHIRD). Endometrioma, identified in 17-44% of women with endometriosis, is the cystic lesion of ovaries filled with the degenerated blood products originating from the ectopic implanted endometrial glands and stroma. Spatial occupation and local reaction led to impaired ovarian reserve and subfertility. Surgical excision may be helpful to avoid further ovarian damage. However, oophorocystectomy appears to have temporary adverse effects on ovarian reserve. AMH was significantly reduced at one-month post-cystectomy and recovered by six months, but not back to baseline values. Large endometrioma (cyst size>= 5 cm) and bilateral presentation are associated with a greater decline in AMH after cystectomy. Inadvertent removal of normal ovarian tissue and excessive hemostasis by electrocauterization can lead to impaired ovarian reserve.

Minimally invasive surgery is the current trend in the management of ovarian cysts, mainly because of the faster recovery time and shorter hospital stay. In recent years, the application of robotic surgery in gynecology has been increasing, not only limited to benign lesions, but also includes staging surgery for gynecological cancer. Compared with laparoscopic surgery, robotic surgery has better instrument range of motion due to Endo-wrist, arm stability, and improved visualization. Sharpness of the Xi endoscope plus can be adjusted from the surgeon console to address a dynamic surgical field, which provides an immersive surgical experience. Fluorescence imaging has been applied for sentinel lymph node mapping for endometrial cancer. The da Vinci Firefly Imaging System provides real-time assessment of vessels, blood flow and related tissue perfusion using near infrared imaging. Endometriosis can appear in a wide variety of appearances and colors under standard white light imaging, making it difficult to be distinguished intraoperatively. Past research revealed that endometriosis is hypervascular, which could be detected by the Firefly Imaging System of fluorescence imaging with ICG dye, allowing for better visual diagnosis during an endometriosis resection procedure. This may be beneficial for patients with this disease.
With highly-magnified 3DHD vision and true depth perception, it may have better performance on identifying and separating the plane of chocolate cysts from normal ovarian tissue; sparing the vessels to avoid unnecessary bleeding, and subsequent suturing.
Therefore, removal of healthy ovarian tissue and excessive use of cauterization when achieving hemostasis could be prevented.

We used the latest Da Vinci Xi Plus to show the surgical experience of an infertile ovarian chocolate cyst.
We presented a case of a 34 year-old woman, G1P1, without underlying systemic disease. A right ovarian chocolate cyst was found in 2022/12. She denied dysmenorrhea, menorrhagia, abdominal distension nor urination frequency. Tumor marker of CA-125 was within normal range(17.6U/ml). Trans-abdominal sonography on 2023/01/13 showed a 7 cm right ovarian cyst with sand-like content without intra-tumoral flow. After well explanation to the patient, she was admitted to Zhubei branch of National Taiwan University Hospital for robotic-assisted oophorocystectomy.

稿件編號：V7 臨時稿件編號： 0850	達文西腸沾黏分離和子宮次全切除手術用於先前肌瘤切除術和嚴重骨盆腔沾黏的病人 Robotic enterolysis and subtotal hysterectomy in a previous myomectomy with severe pelvic adhesion 鍾佳翰[1] 莊乙真[1] 亞東紀念醫院[1]
論文發表方式： 影片展示 論文歸類： 內視鏡	Several surgical complications such as chronic pelvic pain, impaired fertility, small bowel obstruction, and complications during subsequent operations can be associated with adhesions. Adhesion formation occurs in 90% of abdominal and pelvic surgeries, with a lower incidence when the surgery is performed laparoscopically. In this report, we presented a case of 44-year-old woman who had a previous myomectomy with chronic low abdominal pain. She also suffered from hypermenorrhea for several months with anemia and the ultrasound revealed her uterus with adenomyosis. Thus, the patient was admitted for surgical intervention. We presented the video of robotic enterolysis and subtotal hysterectomy. As the video showed, there are severe adhesions between uterus, omentum and small bowel. We identify the position of the uterus and any areas of adhesion. Typically, the round ligament is a less adhesive area and can be used as an anatomical landmark. During surgery, we begin separating the adhesions from the surrounding area, constantly searching for the easiest separation point instead of repeatedly separating from the same point. We use proper pressure when grasping and manipulating tissues to achieve traction and counter- traction and make a better visual field of adhesions. Besides, we use cold dissection mostly to avoid possible thermal injury of adjacent tissue. One advantage of starting to separate adhesions from the sidewall is that it allows for a clear view of the adhesion plane. As step and step of adhesionlysis, less and less adhesion remains and the surgical field becomes clearer gradually. During the cauterization, we lift the tissue as much as possible to avoid damaging the underlying intestines. When there are adhesions involving the mesentery or greater omentum, it is necessary to coagulate the blood vessels with bipolar energy before cutting them. In this surgery, adhesions occurred mostly on the posterior wall of the uterus, and the endo-wrist of the Da Vinci robotic arm allows for different angle separation of the adhesions.

稿件編號：V8

臨時稿件編號：
0750

一個通過腹腔鏡診斷的罕見案例：妊娠試驗陰性且 β-hCG 數值正常的輸卵管妊娠

Tubal pregnancy with negative pregnancy test and beta-hCG elevation, an extreme rare manifestation which should be diagnosed laparoscopically

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論文發表方式：
影片展示

論文歸類：
內視鏡

Introduction: Ectopic pregnancy has a wide variety of clinical presentations, and it is still difficult to be 100% accurate even with advanced imaging techniques and the well-understanding in serum beta-hCG test. Undoubtedly, a negative urine pregnancy test (of course, the same as normal serum beta-hCG level) traditionally excludes the differential diagnosis of ectopic pregnancy. Here we would like to report a rare case who has persistent lower abdominal pain, negative urine pregnancy test/normal serum beta-hCG but finally established the diagnosis of tubal pregnancy laparoscopically and pathologically.

Case report:
This was a 40-year-old, para 4, Taiwanese female, who presented in an outpatient's clinic with symptoms of left lower quadrant pain and abnormal vaginal bleeding for 4 months. Initially she declared that she had taken mifepristone (RU-486) twice in 2022/4 at a local medical clinic for dealing with her undesired pregnancy. Suction dilatation and curettage was performed in 2022/5 there for incomplete abortion after mifepristone taking. Serial beta-hCG levels returned to normal (less than 10 U/mL) after surgery quickly from 2022/05. Unfortunately, polymenorrhea and left lower abdominal pain were encountered after that.
Finally, she visited the emergency department in our hospital with severe diffuse lower abdominal pain in 2022/9. After laboratory study, she was diagnosed to have acute pyelonephritis at first due to dirty urine analysis and negative urine pregnancy test. Symptoms relieved little after antibiotics for 8 days. Abdomen CT scan during her re-ER-visit found to have a left adnexal complex mass incidentally, size measuring about 4cm in diameter. She was referred to gynecologic oncologist’s clinic and follow-up ultrasonographic scans for 3 times within 2 months were performed. Due to a negative urine pregnancy test, ectopic pregnancy was excluded from our list of differential diagnosis. Diagnostic laparoscopy was carried out on 2022/12/15 because of this persistent mass accompanied with lower abdominal pain off and on. During surgery, left bulging fallopian tubal mass was found and excised (left segmental salpingectomy) for pathology checkup. It reported a hematocele in fallopain tubal lumen, with blood clots and inactive trophoblastic tissue microscopically, compatible with tubal pregnancy. Post-operative recovery was uneventful and all symptoms disappeared.

Conclusion: An abnormal adnexal mass with history of recent pregnancy could still be possible ectopic pregnancy even negative urine pregnancy test or serum beta-hCG. Diagnostic laparoscopy and pathology assistance could be helpful when the clinical management is confusing.

稿件編號：V9

臨時稿件編號：
0930

腹腔鏡移除嵌入結腸腸腔內之子宮內避孕器及腸道修補
Laparoscopic management of intrauterine device migration into the lumen of rectosigmoid colon

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四季台安醫院[1]

論文發表方式：
影片展示

論文歸類：
內視鏡

Background :
Colon perforation caused by the intrauterine device (IUD) migration is a rare but severe complication that can occur years after the insertion.
In a majority of cases associated with IUD migration, the patients do not express any symptoms, but extrauterine IUD should be removed surgically without delay due to risk of significant injury to adjacent organs.
There are different methods for extracting migrated IUD, which include colonoscopy, laparotomy, or laparoscopy. Due to the rarity of cases like these, the preferred treatment is left for the surgeon to choose.
We demonstrate a case of a 55-year-old female presented in our clinic asking for management of a migrated IUD incarcerated in rectosigmoid colon, which was found via colonoscopy performing for stool occult blood noted during physical examination. The IUD was inserted about 20 years ago, but she got pregnant afterward. Abortion D&C was arranged with failed IUD retrieval. There's no severe symptom other than occasional discomfort over low abdomen. Laparoscopic surgery for IUD removal with repairment of uterus and bowel defects was performed smoothly with good postoperative recovery.

Materials and Methods :
Setting: single hospital
Surgical video review

Result :
Adhesiolysis was performed carefully, separating the uterus and rectosigmoid colon. Terminal end of IUD stem was identified over the uterine serosa area, and IUD arm and stem were pulled out from rectosigmoid colon. The defect of uterine wall and rectosigmoid colon were repaired. Underwater leakage test was performed for confirming the integrity of bowel wall.

Conclusion :
Laparoscopic approach is a safe and appropriate method to manage migrated IUD which penetrating into the lumen of rectosigmoid colon.

稿件編號：V10

臨時稿件編號：
0958

經陰道自然孔洞內視鏡手術應用於卵巢巧克力囊腫切除手術
Transvaginal Natural Orifice Transluminal Endoscopic Surgery (vNOTES) cystectomy of endometrioma

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花蓮慈濟醫院[1]

論文發表方式：
影片展示

論文歸類：
內視鏡

Background
NOTES Developed in mid-2000, it gave the advantages of eliminating the abdominal scar, the risk of visceral and vascular injuries, and limiting hernias, scars, and pain. However, there were some limitations as the instrument restricted operators through a single port which challenged the surgical skills. Endometrioma may cause cul-de-sac obliteration and not be suitable for NOTES. Here, we presented a vNOTES cystectomy of endometrioma.

Patient and Methods
This is a 40-year-old female, P2 (NSD), with chief complaints of intermittent right lower quadrant pain for four years. Transvaginal sonography showed suspected right teratoma or endometrioma with 3.7*3.1 cm in size. Abdominal CT revealed a 3.7 cm well-encapsulated cystic mass without calcification. vNOTES right cystectomy was performed with one 3-cm incision in the posterior fornix and the single port inserted through the vagina. Right ovarian endometrioma was then identified. The cyst wall was carefully separated from the ovary during the operation and sutured with 2-0 vloc for hemostasis.

Result
Total surgical time was 55 minutes with minimal blood loss. The pathology report showed an endometriotic cyst. The postoperative course was uncomplicated, and the patient was discharged on postoperative day two after the Leuplin injection.

Conclusion
vNOTES cystectomy for endometrioma might be a feasible and safe procedure for appropriate cases.

稿件編號：V11 臨時稿件編號： 0957	減少孔洞之達文西手術處理複雜性子宮肌瘤摘除手術 Reduced-Port Robotic surgery for complicated myomectomy 吳佩姿[1] 莊斐琪[1] 楊采樺[1] 黃寬慧[1] 龔福財[1] 高雄長庚紀念醫院[1]
論文發表方式： 影片展示 論文歸類： 內視鏡	Background Uterine leiomyomas are the most common benign uterine tumor in reproductive age. Surgical intervention including hysteroscopy, laparotomy, laparoscopy or robotic assisted myomectomy would be considered for the patients desiring to preserve uterus when the conservative treatments fail. Robotic surgery for complicated myomectomy, defined as surgery involving more than two myomas, diameter of myoma ≥8 cm, or preexisting pelvic adhesions can eliminate the limitation of rigid instruments associated with single-port laparoscopic myomectomy owing to Endowrists. Reduced-Port robotic surgery (RPRS) using a laparoscopic single-port platform with multiport robotic instruments is an alternative method to overcome the disadvantages of robotic multiport or single port-laparoscopic myomectomy. We will present an edited video about Reduced-Port Robotic Surgery (RPRS) for complicated myomectomy. Methods The da Vinci Xi robotic system was used. An approximately 2.5cm vertical incision over the umbilicus was made for the Glove Port (Nelis) and one 8mm trocar was established over the right lower abdomen. The Glove Port consists of four insertion ports with three white ports (all 8mm) and one blue port (12mm) which is for assistant instruments and to pass needles. The da Vinci 30-degree camera was inserted through one of the 8mm ports of the Glove Port. The robotic instruments were placed at another one 8mm port and the additional side trocar, respectively. Results The robotic instruments in right arm established at the additional side trocar was dedicated to tissue incision and multi-layers suturing of the uterus. This setting also saved the time of specimen retrieving through the umbilical vertical wound. Besides, there were only two skin wounds over the patient’s abdomen. Therefore, this application enhanced the cosmetic satisfaction compared to conventional multi-sites myomectomy. Conclusions The advantages from Reduced-Port Robotic Surgery (RPRS) with the use of Glove Port include relatively overcoming collision between instruments, less time for retrieving specimen, more satisfying cosmetic outcome and rapid recovery after operation. Consequently, this application is a feasible and safe surgical method for complicated myomectomy.

稿件編號：V12

臨時稿件編號：
0875

達文西手術於大型子宮肌瘤切除之技巧
Tips and Tricks of Reduced Port Robotic Myomectomy for Large Uterine Leiomyomas

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義大醫院 [1]

論文發表方式：
影片展示

論文歸類：
內視鏡

Background:
Uterine leiomyomas are common benign solid tumors of the uterus. Myomectomy is a standard fertility sparing surgical method and should be considered for women with fibroid related symptoms who do not desire hysterectomy. Recently, laparoscopy and robot-assisted surgery have evolved to deal with complex cases such as large and numerous myomas.

Patient and Methods:
A 40-year-old woman (parity 0, married for 4 years) who presented to our hospital for fertility counseling. Gynecologic ultrasound showed huge uterus (>20 cm) with multiple leiomyomas. Magnetic Resonance Imaging revealed an enlarged 14 cm-leiomyoma.

Results:
Reduced port Robotic myomectomy was performed smoothly. V-Loc 1-0 was used to approximate the uterus. The weight of leiomyoma is 985g. Blood transfusion of 3-unit PRBC was done due to Hb drop from 12 to 8. The patient recovered well and discharged 5 days after the operation.

Conclusions:
Patients with large myoma are more likely to suffer from intraoperative complications, such as more blood loss resulting with the need of blood transfusion. On these difficult cases, robotic assisted surgery has the advantage of tumor traction and suture. In this video presentation, we will show the tips and tricks of reduced port robotic surgery.

稿件編號：V13

臨時稿件編號：
0905

在子宮穿孔後持續使用 Truclear 進行子宮鏡手術的技巧與經驗分享
Tips and Tricks of Continuing Hysteroscopic Surgery with Truclear after Complication of Uterine Perforation

楊憶[1] 張裕[1] 桂羅利[1]
義大醫院婦產部[1]

論文發表方式：
影片展示

論文歸類：
內視鏡

<Introduction>
The Truclear system is another minimally invasive technique used to remove endometrial tissue. This procedure can be complicated with uterine perforation, which is a serious complication that requires prompt attention. In rare cases where the uterine perforation is small and uncomplicated, and the healthcare provider determines that it is safe to continue the procedure, they may choose to do so. In this video, we demonstrate a case of uterine perforation while inserting the Truclear system. The remaining procedure was still carried on smoothly.

<Case report>
This 68 y/o woman has a known history of sigmoid colon subepithelial tumor. Computed tomography revealed an uterine cystic lesion. Hystreoscopic surgery with the Truclear system was arranged. However, cervical dilatation was difficult due to severe cervical atrophy. Uterine perforation unfortunately occurred while inserting the device. Despite the setback, hysteroscopic removal of endometrial lesions was still completed without further complications.

<Discussion>
In cases where hysteroscopic surgery is complicated by uterine perforation, the physician should take prompt measures to assess the extent of the perforation and the risk of further complications. Depending on the severity and location of the perforation, the provider may choose to stop the procedure or continue under close monitoring. In our case, the uterine perforation was small and uncomplicated. We demonstrate that continuing hysteroscopic surgery after uterine perforation can be considered after a thorough assessment of the patient's condition and the risks and benefits of continuing the procedure.

稿件編號：V14 臨時稿件編號： 0852	以腹腔鏡肌瘤切除手術治療敏感位置病灶的技術分享 Techneques in laparoscopic myomectomy to treat intricately situated lesions 李佾潔[1] 孫仲賢[1] 高雄四季台安醫院[1]
論文發表方式： 影片展示 論文歸類： 內視鏡	Background Uterine fibroids are notorious about their potential to enlarge in size and locate diversely. Laparoscopic myomectomy has been widely accepted as a surgical removal option to treat uterine fibroids, while the features of laparoscopy may simplify or complicate such surgical procedure. To achieve radical removal of the lesion, and maximal preservation of normal organs are the two ends of the scale to be balanced during laparoscopic myomectomy. Patient and Methods We herein present our surgical videos of laparoscopic myomectomy to treat large type 3 myoma and paracervical broad ligament myoma. Results Endometrial preservation is crucial during the excision of large type 3 myoma in patients with fertility consideration. In such occasions, multidisciplinary cutting techniques should be taken to achieve optimal outcome. In paracervical broad ligament myoma, sparing enough myometrium in advance and avoidance to injure the vital organs are the key points to perform a relaxed repair procedure. Conclusions Laparoscopic myomectomy may be irritating if the myoma is intricately situated. Certain principles and pre-emptive tactics should be kept in mind to avoid awkward process and outcome.

稿件編號：V15

臨時稿件編號：
0887

經陰道自然孔手術中之縫合技術分享
Suturing Skill and Technique under Transvaginal Natural Orifice Transluminal Endoscopic Surgeries

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論文發表方式：
影片展示

論文歸類：
內視鏡

Background:
In natural orifice transluminal endoscopic surgery (NOTES), the natural orifices of the human body are used to access the abdominal cavity to perform surgery. Since transvaginal NOTES is introduced in 2012, many surgeons have developed the technique in various gynecologic procedure, such as oophorectomy, salpingectomy, adnexectomy, hysteromyoma and hysterectomy.

Patient and Methods:
A 41-year-old woman (gravida 0, sexual activity history+) who presented to our hospital complaining of ovarian cyst with lower abdominal pain. She denied any operative history. She had symptoms for about 3 months so that she went to local clinical department for help. Ovarian cyst was told by doctor there. Due to above reasons, she came to our outpatient department for help. Gynecologic ultrasound revealed left complex ovarian tumor sized 8.4 x 6.4cm. Computed tomography (CT) also confirmed bilateral adnexal with mixed fat, soft tissue and calcification; right adnexal tumor sized 6.9 x 5.2 x 5.8 cm and left adnexal tumor sized 5.7 x 4.7 x 8.3 cm. Tentative diagnosis was bilateral teratoma. After discussed, patient decided to receive surgical treatment.

Results:
Transvaginal natural orifice transluminal endoscopic bilateral ovarian tumor enucleation was performed. Bilateral ovarian tumor contained with lipid, skin, hair, and bone tissue. Histopathological examination showed that mature cystic teratoma, negative for malignancy. Finally, the patient recovered well and discharge 3 days after the operation.

Conclusions:
Advantages of NOTES include faster postoperative recovery, reduced postoperative pain, and decreased postoperative wound infections, as well as outstanding cosmetic results. Even though most studies reported a shorter operation time for transvaginal NOTE cystectomy compared to conventional laparoscopic cystectomy, the suturing skill and technique under NOTES still need learning and practice for beginner-surgeon.

稿件編號：V16 臨時稿件編號： 0916	切除骨盆腔側壁復發性深部浸潤子宮內膜異位症病灶引發輸尿管及血管損傷之個案處理報告 Ureter and vascular injury during laparoscopic excision for recurrent pelvic sidewall deep endometriosis 孫仲賢[1] 方俊能[1] 侯詠齡[1] 莊國泰[1] 四季台安醫院[1]
論文發表方式： 影片展示 論文歸類： 內視鏡	Introduction: Pelvic sidewall deep endometriosis (DE) is not easy to completely excise during laparoscopic surgery, due to distorted anatomy and the dense fibrosis. Recurrent sidewall DE after previous hysterectomy is even more difficult to operate, due to the loss of tissue plane, collapsed retroperitoneal space without uterus, and much denser fibrosis. Injury to the retroperitoneal structures (including ureter, vessels, and nerves) is not uncommon. In this video, we will demonstrate a case with previous laparoscopic subtotal hysterectomy plus posterior DE excision. During the surgery for recurrent left ovarian endometrioma, and sidewall DE, we encountered troublesome multiple ureter injuries and vascular injuries. Materials and methods: Video review and editing. Result: The 45-years old lady had previous laparoscopic subtotal hysterectomy, plus posterior DE excision for adenomyosis and severe pelvic endometriosis. Recurrent Left ovarian endometrioma (6 cm in diameter) was noted during the follow up period. During the surgery, this time, not only left ovarian endometrioma, but also left pelvic sidewall DE lesions were noted. We performed laparoscopic adhesiolysis, left salpingo-oophorectomy, and DE excision for her. Due to the distorted anatomy, and the very dense retroperitoneal spaces, we encountered multiple ureter injuries, including thermal injury and partial transection. Multiple vascular injuries were also noted during the difficult ureterolysis. Careful vascular repair, and then ureter segmental resection with end-to-end anastomosis (uretero-ureterostomy) were performed. The techniques of laparoscopic vascular repair and uretero-ureterostomy will be highlighted. Conclusion: Resection of recurrent sidewall DE is a challenging surgery, because of the distorted anatomy and the dense fibrotic retroperitoneal space. Ureter injury and terrible vascular injury may be encountered. Surgical team should be well trained to deal with these kind of complications.

稿件編號：V17

臨時稿件編號：
0885

超音波導引經陰道抽吸術合併子宮直腸窩切開引流術作為一種有效的第一線治療急性輸卵管卵巢膿瘍的方式：一個案例系列報告

Ultrasound-Guided Transvaginal Aspiration in Combination with Culdotomy Drainage as an Effective First-Line Treatment for Acute Episode of Tubo-ovarian Abscess: A Case Series

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論文發表方式：
影片展示

論文歸類：
內視鏡

Ultrasound-Guided Transvaginal Aspiration in Combination with Culdotomy Drainage as an Effective First-Line Treatment for Acute Episode of Tubo-ovarian Abscess: A Case Series

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Objective:
To demonstrate the safety and effectiveness of ultrasound-guided transvaginal aspiration, culdotomy and drainage tube placement for treating acute episode of tubo-ovarian abscess (TOA).

Materials and Methods:
During 2022, three consecutive women with a diagnosis of TOA were advised to undergo the procedure. All patients presented with low abdominal pain, elevated levels of C-reactive protein and cancer antigen 125, with some having fever and leukocytosis. Intravenous infusion of broad-spectrum antibiotics was prescribed for all patients. Under general anesthesia, the patients were placed in lithotomy position, and a Double Lumen Ovum Pickup Needle (No. 16, Cook Medical) was used to penetrate the lesion for pus aspiration. Back-and-forth irrigation was then performed under transvaginal ultrasound guidance. Culdotomy was subsequently performed, and the pelvis was vigorously irrigated with normal saline. Penrose drainage tubes were placed to finish up. (A video of the procedure will be available upon presentation.) The patients were admitted for postoperative continuous antibiotic administration and observation.

Result:
All patients underwent the procedure successfully without any complications. The amount of fluid aspirated ranged from 40ml to 250ml, and the operating time ranged from 76 to 177 minutes. They all underwent culdotomy, with one left open for drainage, while the other two had Penrose drainage tubes inserted. The drainage tubes were removed either on day 2 or 4 after the procedure. All patients experienced improvement in symptoms, and their post-operative hospital stays ranged from 1 to 3 days. Follow-up ultrasound imaging at outpatient department showed normalization of bilateral adnexa in one case, a reduction in the size of TOA in another case, and loss of follow up in the last case.

Conclusion:
Ultrasound-guided transvaginal aspiration of TOA is a safe and effective procedure. Concomitant culdotomy with drainage tube placement can aid in continuous drainage of the purulent pelvic fluid and hopefully accelerate recovery.