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生產事故關懷模擬演練 (一)

李詩應醫師、法學碩士、法學博士

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- 角色分配：事前作業
- 案例影片觀看與回應選擇：事前作業
- 案例說明與回應選擇分析 10 分鐘
- 全體討論：15 分鐘 (問題及引導)

由生產事故關懷模擬演練 (二) 接續進行。

透過生產事故案例對話經過影片觀賞及現場模擬演練探討分析及討論關懷的重點與關鍵。以提供熟悉將來可能面對的情況及如何因應面對的準備。

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生產事故關懷模擬演練 (二)

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- 分組演練：二輪 20 分鐘 (依實際演練狀況調整)
- 分享與結論：15 分

透過生產事故案例對話經過影片觀賞及現場模擬演練探討分析及討論關懷的重點與關鍵。以提供熟悉將來可能面對的情況及如何因應面對的準備。

羅良明

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中華民國醫師公會全國聯合會 111 年度
台灣醫療貢獻獎

胎盤完全前置剖腹生產的計畫與執行

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Placenta previa is defined as the condition where the placenta directly overlies the cervix, which occurs in 4 to 5 of 1000 pregnancies. It may increase the risk of placenta accreta spectrum disorder and the risk of vasa previa. Placenta previa is also one of the major causes of antepartum hemorrhage and postpartum hemorrhage. It may firstly seen at approximately 18 to 20 weeks of gestation. However, most of those cases will resolve lately. When one is definitive diagnosis of placenta previa, several factors must be considered, including placental location, history of antepartum hemorrhage, symptoms of preterm labour, cervical length, parity, and history of cesarean delivery or prior uterine surgery. Ultrasound should be done before the operation to assessment the placental location and the possibility of placenta accreta.

Cesarean section is recommended for all women with a placenta previa. The optimal timing of delivery would be at 36 0/7 to 37 6/7 weeks of gestational age. If significant vaginal bleeding noted accompanied by category III fetal heart rate or maternal hemodynamic stability, emergent cesarean delivery must be performed regardless of the gestational age. Transection of the placenta should be avoided when entering the uterus. A vertical incision of uterus above the placenta is considered if anterior placenta found under ultrasound. If incision of placenta is unavoidable, fetus should be delivered soon after placenta incised. Red blood cells should be available for the operation. Pelvic angiography and embolization is consider arranged before cesarean section if placenta accrete is suspected before cesarean section. Oxytocin is given routinely to reduce the risk of postpartum hemorrhage and tranexamic acid can be considered as well. Monitoring maternal blood loss and hemodynamic statu is also important during the operation. Once we face postpartum hemorrhage, uterotonic drug should be applied first follow by standard surgical interventions (including hemostatic square sutures, uterine and utero-ovarian arteries ligation and uterine compression suture). In refractory patients, arterial embolization or hysterectomy should be considered. In this section, I will share our experience in managing placenta previa and try to propose a flow diagram of placenta previa management.

童寶玲

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如何避免腹腔鏡併發症

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Laparoscopic surgery has many advantages but it is not without complications. Definitions of complications vary and they are usually under-reported. The reported overall complication rates range from 0.2% to 10.3%. The risk of complication is dependent on patient characteristics (age, BMI), comorbidities (previous surgery), complexity of the surgery (adenomyosis, endometriosis), and surgeons' expertise. Laparoscopic surgeons ought to be aware of the possible complications and how they could be prevented, recognized without delay, and managed safely and efficiently. Important complications include injuries to the vessels, bowel and urinary tract. Shoulder pain is a minor complication but is exceedingly common. Incisional hernia could be reduced by careful closure of the fascia. Other rare complications include pneumothorax, subcutaneous and pre-peritoneal emphysema, cardiac arrhythmia, nerve injury, venous thrombosis and gas embolism, which is a potentially life-threatening complication.

The incidence of bowel injury is 0.13% for laparoscopy procedures. The most common site of bowel injury is the small bowel, follow by the large bowel and stomach. Important principles of prevention include proper pre-operative evaluation and increased laparoscopic surgical skills and knowledge. Bowel injury may occur during insertion of a Veress needle and trocar, use of electrosurgery, suturing, and adhesolysis. Electrosurgery should be carefully used to avoid complications arising direct coupling and insulation failure. Early recognition of bowel injury is crucial for a favorable clinical outcome.

The urinary tract injury rate for laparoscopic hysterectomy is around 0.73%. Most bladder injury are recognized intraoperatively and the majority of ureteral injury are recognized postoperatively. Skills to prevent urinary tract injury are: 1. Use appropriate instruments, e.g., uterus manipulator. 2. Coagulate uterine vessels close to the uterus from ipsilateral side with a perpendicular approach, i.e., minimizing risk on bleeding and enlarge distance between uterine artery and ureter. 3. Complete a ureter visualization in case of distorted anatomy before coagulation can take place.

Surgeon' s experience is strongly associated with risk of major postoperative complications. The standardization of the surgical technique, the best MI approach (laparoscopy or robot-assisted) are crucial tools to decrease complications in MIS.

Conversion to open surgery is an unpredictable condition in MIS. Although it might be necessary during difficult MIS to prevent or to minimize further complication, a huge effort should be made to minimize the need for conversion to open surgery.

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How to improve your laparoscopic skills?

Laparoscopic surgery has become the gold standard approach for many surgical procedures. There are numerous challenges that surgeons in training can face when developing their laparoscopic skills. The topic today is to share the tips for trainees who are interested in maximising their learning opportunities in laparoscopic surgery, offering different methods to guide them in improving their laparoscopic skills.

The following tips to be shared today.

- (1) Increasing your exposure
- (2) Regular simulation training
- (3) Choosing a suitable task to your level of experience
- (4) Learning anatomy
- (5) Set milestone and identify the tasks to be achieved

Laparoscopic surgery is challenging and unless it is performed on a frequent basis, laparoscopic skills are not easily maintained. Trainees at the early stage of their surgical career are strongly encouraged to take active steps in being involved in laparoscopic training

Reference:

(1) Sant'Ana GM, Cavalini W, Negrello B, Bonin EA, Dimbarre D, Claus C, Loureiro MP, Salvalaggio PR. Retention of laparoscopic skills in naive medical students who underwent short training. *Surg Endosc.* 2017 Feb;31(2):937-944.

(2) Cavalini WL, Claus CM, Dimbarre D, Cury Filho AM, Bonin EA, Loureiro Mde P, Salvalaggio P. Development of laparoscopic skills in medical students naive to surgical training. *Einstein (Sao Paulo).* 2014 Oct-Dec;12(4):467-72.

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如何執行子宮腔鏡及避免併發症

Office hysteroscopy can be considered the gold standard for the examination of the uterine cavity. Overcoming the limitations of D&C and other blind techniques. Several tips and tricks are needed to optimize successful rate of an office hysteroscopy, either diagnostic or operative.

The standard rigid hysteroscopes had a diameter > 5 mm and sometimes required cervical dilatation and local or general anesthesia.

The recent trend of reducing the size and diameter of hysteroscopes has largely contributed to the performance of hysteroscopy as an ambulatory procedure. Flexible hysteroscopes with a smaller diameter have demonstrated several advantages over the standard rigid ones in several studies.

Vaginoscopy is the method of atraumatic insertion of the hysteroscope into the external uterine orifice, without the aid of the speculum or the tenaculum, introducing the scope directly into the vaginal canal. This method reduces patient discomfort and allows the performance of endoscopic examination even in patients with intact hymen.

The aim of operative hysteroscopic is “see and treat” of benign changes of the uterine cavity. Operative hysteroscopy plays a pivotal role in surgical management of subfertility and recurrent pregnancy loss aiming to restore cavity anatomy and also provides diagnostic workup for abnormal uterine bleeding, treatment of heavy menstrual bleeding.

Operative hysteroscopic surgery has classically been performed with an instrument called a resectoscope.

There are 3 types of current that can be used in the resectoscope:

- Monopolar : In order for the current to flow, a non-conductive media must be used, such as sorbitol or glycine.
- Bipolar : In this setting, conducting distention media can be used safely.
- Intrauterine Morcellation : In this setting, no electrical energy in the uterus reduces the risk of air or gas emboli and the risk of patient harm.

Contraindications — The contraindications are the same as hysteroscopic surgery (eg, active pelvic infection, intrauterine pregnancy, cervical or uterine cancer ?). Medical comorbidities (eg, coronary heart disease, bleeding diathesis) are also potential contraindications to hysteroscopic surgery.