稿件編號：V1 臨時稿件編號： 1206	腹腔鏡子宮薦椎韌帶懸吊術的手術技巧 Tips and Tricks for Effective Laparoscopic Uterosacral Ligament Suspension 侯詠齡[1] 孫仲賢[1] 李佾潔[1] 莊國泰[1] 高雄四季台安醫院[1]
論文發表方式： 影片展示 論文歸類： 婦女泌尿	Background: A great variety of surgical techniques for apical pelvic organ prolapse (POP) have been reported. Apical procedures can have an effect on multiple levels of Delancy. The main goal of apical procedures is to restore level 1 support, but it can also have an impact on level 2 defects. The anatomic success rate of the laparoscopic uterosacral ligament suspension was 90% and an apical recurrence of 10% that we found in a review. Only the laparoscopic sacrocervicopexy seems to be superior according to the literature. No difference was found regarding complications, postoperative pelvic pain, dyspareunia or de novo stress incontinence. Even though the use of abdominal mesh has a lower risk of complications compared with vaginal mesh, a growing number of women and physicians have reservations regarding the use of mesh and prefer native tissue repair. The advantage of the laparoscopic uterosacral ligament suspension over via vaginal route is the superior visualization of the anatomy and localization of the ureters and hypogastric nerves. This minimalizes the risk of ureteral injury and obstruction, allowing safe high suture placement and good apical support. Materials & methods: Surgical video from a case with adenomyosis and stage 2 uterine prolapse. Results: Laparoscopic subtotal hysterectomy was performed under carefully retroperitoneal monitoring. Okabayashi pararectal space was open first with ureter lateralized as well as uterine vessels. Then the hypogastric nerve was identified and lateralized in order to prevent incorporating the nerve while performing uterosacral ligament suspension. Last, the peri-rectal space was open (between rectum and uterosacral ligament) in order to isolate uterosacral ligament all the way to the level near the sacral bone and thus allowing deep suture bite of the ligament. Conclusions: For patient with uterine pathology indicated of hysterectomy and accompany with apical prolapse, concomitant laparoscopic uterosacral ligament suspension is a promising procedure for restoring level 1 and level 2 support.

稿件編號：V2

臨時稿件編號：
1043

以達文西機器手臂施行子宮頸薦骨固定術及 Burch 陰道懸吊術來治療同時有骨盆底器官脫垂及應力性尿失禁之患者

Robotic sacral cervicopexy and Burch colposuspension for patient with concomitant stress urinary incontinence and pelvic organ prolapse surgery

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論文發表方式：
影片展示

論文歸類：
婦女泌尿

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Background:
Pelvic organ prolapse (POP) is common in women and is frequently associated with stress urinary incontinence (SUI). In some cases, SUI is present only with the prolapse reduced (occult SUI) or may develop after surgical treatment for prolapse (de novo SUI) [1].
However, for patient with preoperative symptomatic SUI, Silvia Pecchio et al. concluded that clinically incontinent patients with MUCP ≤50 cmH2O will gain the greatest benefit from concomitant POP and SUI surgery. [2]
Kaven Baessler et al. also cocluded that In women with POP and SUI (symptomatic or occult), a concurrent SUI surgery probably reduces postoperative SUI and should be discussed in counselling.[1]
Ericka M Sohlberg et al. proposed that a Burch procedure should be considered when vaginal access is limited, concurrent intra-abdominal surgery is planned, or mesh is contraindicated.[3]
For patient who didn't have SUI before POP surgery, Linda Brubaker et al concluded that in women without SUI who are undergoing abdominal sacrocolpopexy for prolapse, Burch colposuspension significantly reduced postoperative symptoms of SUI without increasing other lower urinary tract symptoms.[4]
Drancourt E et al. also concluded that Sacral colpopexy combined with Burch operation is a reliable solution for repair of USI with marked cystocele. [5]
Aims and objective:
To observe the feasibility and outcome of robotic sacral cervicopexy and Burch colposuspension for patient with concomitant stress urinary incontinence and pelvic organ prolapse surgery.
Methods
Case
We reported a 58 y/o Gravida 2 and Para 2 female who had concomitant stress urinary incontinence and pelvic organ prolapse (Cystocele stage III, uterine prolapse II) and receive robotic sacral cervicopexy and Burch colposuspension at our hospital.
Surgical Technique
We use Da vinci robotic Si system with 5 ports techniques. The scope was set in the trocar on the umbilicus, the arm 1, arm 2, arm 3 assistant ports on the anterior abdominal wall.
Sacral cervicopexy is an abdominal-prolapse repair that restores pelvic anatomy
In sacral cervicopexy, graft material is attached between the cervix and sacrum supporting the vagina Burch colposuspension was performed through the same incision as the Sacral cervicopexy. The Burch colposuspension consists of suturing periurethral vaginal tissue to the iliopectineal (Cooper's) ligaments on each side to

support the urethra.

Result
Success for pelvic organ prolapse was achieved (absence of prolapse beyond the hymen) and her stress urinary incontinence improved after surgery (no need for protective pads. No injury to the bladder, bowel, vagina, ureters, or vessels were noted during 1 month follow up.
She had only a little urinary frequency which improved after using antimuscarinic medicine.
Conclusion
The effectiveness of Burch for POP patient with or without SUI may need well-powered trial to clarify, but it's a feasible and safe surgery and do obviously improve the symptoms of our care.
Although Midurethral slings are the mainstay of stress incontinence treatment; however, diversity of surgical options is needed to serve the large number of patients desiring treatment. The Burch colposuspension remains a viable treatment option for appropriately selected patients.[6]
H Sekine et al. ever mentioned about the effectiveness of Burch colposuspension combined with vaginal repair for manage various pelvic hypermobility symptoms[7], which correspond to the improvement of our patient.
Robotic endowrist technology may help the surgeon to approach challenging angles during this complicated surgery and perform dissection and suture delicately.
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稿件編號：V3 臨時稿件編號： 1127	使用旋轉性皮瓣及經會陰直腸粘膜環形切除肌層折疊手術修補嚴重肛門直腸脫垂 Using rotational vaginal flaps and delorme's procedure to repair advanced anorectal prolapse 陳怡婷 [1] 楊恬欣 [1] 台大醫院婦產部 [1]
論文發表方式： 影片展示 論文歸類： 婦女泌尿	[Case presentation] Our case is a 68y/o P3(NSDx3) woman. Her BMI was nearly obese. Her had suffered from rectal prolapse for 5 years with stool incontinence. Her medical histories were significant of multiple cormorbidities. Due to rectal prolapse, she had received laparoscopic proctectomy and rectopexy in 2022. However, according to the patient, the rectal prolapse recur just 3 days after the surgery. On pelvic examination, stage 3 cystocele, uterine prolapse, and rectocele were noted with a huge anal prolapse. Therefore, we gave her pretreatment with cubic pessary for 2 weeks. Surgical procedure included loop-t colostomy by colorectal surgeon and we performed VTH and A-repair first and then dissected into rectovaginal septum. [Video demonstrated rotational vaginal flaps and the process of posterior colporrhaphy + culdoplsty + delorme's procedure] After completion of the surgery, no more rectal prolapse was seen. At 6-month follow-up. There was fair perineal wound healing and no obvious pelvic organ prolapse. [Discussion] Definition of rectal prolapse is intussusception or protrusion of rectum through anus. Associated symptoms include fecal incontinence, constipation, bleeding or mucosal discharge. Rare complication includes strangulation and bowel necrosis. Risk factors included multiparity, obesity, CNS and connective tissue diseases. According to Altemeier in 1971, the rectal prolapse can be classified into three types according to its severity. Type I is the least severe type with only mucosal prolapse; type III is the more severe type with complete, full thickness rectal intussusception in recto-anal canal through sphincter + the sliding hernia of CDS. Common anatomy features include Diastasis of Levator ani, abnormally deep CDS, redundant rectosigmoid patulous anal sphincter and loss of sacral attachments. Rectal prolapse might have complex pathophysiology which started from redundant rectosigmoid colon which later formed rectal intussusception. Obstetric injury can cause recto-vagianl fascia weakness which lead to downward migration of rectovaginal septum and CDS. In the end, the anorectal prolapse occurred. Due to the complex pathophysiology of rectal prolapse, we need a comprehensive management. That is using the rotational vaginal flaps to strengthen the weak pelvic floor. And use the Delorme’s procedure to resect the redundant rectal mucosa. Together, we might reach the treatment goal of restoring normal anatomy and possiblely improve the bowel function of this patient.

稿件編號：V4

臨時稿件編號：
1029

慢性子宮附屬器扭轉與肺栓塞導致延遲手術
Chronic adnexal torsion and pulmonary embolism causing delayed surgical intervention

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論文發表方式：
影片展示

論文歸類：
一般婦科

Introduction
The incidence of pulmonary embolism in adnexal torsion was reported to be low, about 0.2%. Pulmonary embolism is believed not to be predisposed by the procedure of surgical detorsion. This case report presented a case of chronic ischemic ovarian torsion, who presented with pulmonary embolism. Due to medical and anti-coagulant therapy, her surgical intervention had to be postponed to 3 months later.
Case Report
This 52-year-old, menopausal female, presented at emergency department with sudden onset of shortness of breath, oxygen desaturation and persistent right lower quadrant abdominal pain for two weeks. Bilateral pulmonary embolism was diagnosed and she was admitted for intensive care first. A huge lower abdominal mass, measuring 19.7x12.7x17.1cm, was found by abdominal CT scan. Due to medical therapy and unstable pulmonary function, surgical intervention was decided to be postponed until stable pulmonary condition. Three months later, laparoscopy was carried out. Extensive abdominal adhesion was found among this tumor, anterior parietal peritoneum, omentum, mesocolon, appendix and mesentary of terminal ileum. A right ovarian tumor with pedicle strangulation was identified after extensive adhesion-lysis. Right salpingo-oophrectomy without detorsion was completed and specimen was removed without tumor rupture or spillage. Pathology reported to be a totally ischemic necrotic epithelial tumor. Her recovery was uneventful after surgery.
Conclusion
Gynecological adnexal torsion with pulmonary embolism was extremely rare. When these two situations are encountered, delayed surgical intervention would be safer for decreasing co-morbidity during/after surgery. However, surgeon should pay attention to extensive adhesion while delaying surgery.

稿件編號：V5

臨時稿件編號：
1078

兩孔腹腔鏡手術在深部浸潤性子宮內膜異位症中的手術程序與腹膜後解剖構造識別

Surgical Procedures and Retroperitoneal Anatomy Identification in 2-Port Laparoscopic Cystectomy for Deep Infiltrating Endometriosis

楊晴嵐[1] 莊乙真[1] 鍾佳翰[1] 李大成[1] 陳曦[1]
亞東紀念醫院婦產部[1]

論文發表方式：
影片展示

論文歸類：
內視鏡

Objective
This article aimed to demonstrate the surgical steps involved in a 2-port laparoscopic cystectomy for a patient with deep infiltrating endometriosis (DIE), and the identification of retroperitoneal anatomy during the procedure.

Patient
We reported a 34-year-old nulligravida female who suffered from severe dysmenorrhea. Bilateral ovarian endometriomas and deep infiltrating endometriosis was suggested by ultrasonography. In light of the debilitating symptoms and compromised quality of life, the patient was scheduled for surgery.

Interventions
A 2-port laparoscopic surgery was performed with one 10-mm trocar through the umbilicus, and an accessory 3-mm port on the left lower abdominal wall. During the operation, the abdominal and pelvic cavity was inspected. Bilateral ovarian endometriomas were observed, dissected and enucleated. Besides, millimetric foci of endometriosis were observed on the parametrium in the parietal pelvic peritoneum over the bladder-uterine cavity, both uterosacral ligaments and cul-de-sac. Both ureters and retroperitoneal space were meticulously identified. Endometriotic lesions were destroyed by electrocoagulation.

Conclusion
The surgical management of deep infiltrating endometriosis demands a high level of surgical expertise due to its complexity. Accurate identification of retroperitoneal anatomy is a crucial determinant for the success of the operation and plays a important role in minimizing the risk of surgical complications.

稿件編號：V6

臨時稿件編號：
1082

達文西手術處理復發性之卵巢顆粒細胞瘤
Robotic surgery for recurrent ovarian granulosa cell tumor

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論文發表方式：
影片展示

論文歸類：
內視鏡

Background:
Granulosa cell tumors (GCT) of the ovary are considered as low-grade malignancies with a relatively more favourable prognosis when compared with the more common epithelial ovarian tumours [1]. Despite this generally favourable clinical behaviour, a certain percentage of patients diagnosed with GCT still suffer from recurrence and disease-related mortality [2]; unfortunately, not only the rarity of GCT, but also its slow progression and the long time period for which follow-up observation is required, make it difficult to clearly understand the clinical course of the disease, provide adequate treatment guidelines and recognize the prognostic factors for recurrence and death. Because GCT is a tumor with low malignant potential, its overall sensitivity to chemotherapy is relatively poor. Dan Zhao et al. concluded in their study that among patients with recurrent GCT, those with long progression-free survival (PFS) had good prognoses. Maximal cytoreductive effort should be made after recurrence. Complete resection and postoperative adjuvant chemotherapy may improve the prognosis of patients with recurrent GCT [3].

Aims and objective: To observe the feasibility of robotic surgery for treating recurrent ovarian granulosa cell tumor.

Methods

Case : We reported a 46 y/o nulligravida female had recurrent GCT. She had pT1c1N0MB, FIGO stage IC1 bilateral GCT when she was 38 y/o and ever received fertility-sparing cytoreductive surgery (right oophorectomy while preserve the left ovary) and 2 cycles of adjuvant chemotherapy with BEP regimen (bleomycin, etoposide, cisplatin). After chemotherapy course completed, she tried in vitro fertilization and embryo transfer for conception for several times but no successful pregnancy. During the same period, her suspected recurrent GCT over left ovary was noted and she finally decided to received surgery for complete resection (hysterectomy and left oophorectomy) at 6 years after her initial surgery. And she received another 4 cycles of adjuvant chemotherapy with EP regimen (etoposide, cisplatin) after her second cytoreductive surgery. 2 years after her second surgery (8 years after initial surgery), she had recurrent peritoneal seeding tumors and receive robotic surgery for recurrent ovarian granulosa cell tumor

Surgical Technique: We use Da vinci robotic Si system with 5 ports techniques. The scope was set in the trocar on the umbilicus, the arm 1, arm 2, arm 3 assistant ports on the anterior abdominal wall. With the 3D vision and endo wrist of robotic arm, it is feasible to lysis of the severe adhesion between the recurrent ovarian tumor and bowel without severe injury the bowel.

Results: Seeding tumors at pelvic wall, small intestine and colon noted (greatest diameter about 10cm at right anterior pelvis) and severe pelvic-abdominal adhesion was noted during surgery. The main lesions adhered to the bowel was resected successfully. Postoperative oral feeding progressed well she can tolerate full diet and discharge smoothly at postoperative day 5th.

Conclusion: The treatment and outcomes of recurrent GCT remain uncertain and some studies reported that complete resection may improve the prognosis [3,4,5].
With the 3D vision and endo wrist of robotic arms, it is feasible to lysis the severe adhesion between the recurrent GCT and bowel and make maximal cytoreductive effort without severe injury to the bowel.

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稿件編號：V7

臨時稿件編號：
1213

子宮內膜癌分期手術後感染性淋巴囊腫的達文西沾黏分離術
Robotic Lysis of Infective Lymphocele After Endometrial Cancer Staging

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論文發表方式：
影片展示

論文歸類：
內視鏡

Introduction:
Though sentinel lymph node navigation shows promise, for numerous patients with advanced-stage endometrial cancer, lymphadenectomy continues to be the primary treatment modality. Nevertheless, performing a comprehensive nodal dissection still carries a significant risk of long-term complications, such as lymphedema and lymphocele.

Method:
We presented the case of a 37-year-old woman diagnosed with stage IB endometrial cancer. She underwent a Da Vinci robotic staging procedure involving total hysterectomy, bilateral pelvic lymph node dissection, and para-aortic lymph node sampling. Following the surgery, she received adjuvant radiotherapy due to the extent of myometrial involvement > 1/2. Unfortunately, three months later, she experienced the development of an infectious lymphocele and a pelvic abscess, accompanied by intermittent right leg edema and pain. A CT scan revealed external compression on the bladder due to the lymphocele. Despite a two-week course of antibiotics, her condition did not improve.

Owing to the patient having received radiotherapy and the lymphocele near the major vessel, a CT-guided aspiration was not considered. Instead, we performed robotic lysis of infective lymphocele and double J catheter insertion. By using a robotic needle holder with blunt dissection, we carefully dissected the peri-vessel area around the bifurcation of the right common iliac artery and addressed adhesions involving the transverse colon. The intervention successfully drained the abscess, and the patient made a full recovery.

Results:
The surgical video of the robotic lysis and drain of the abscess will be shown.

Conclusion:
Utilizing the Endo wrist of the robotic instrument, we were able to effectively dissect severe adhesions associated with the infective lymphocele. Additional research will be necessary to further validate our procedure.

稿件編號：V8

臨時稿件編號：
1140

在嚴重腹腔沾黏患者上使用腹腔鏡不同視角進行沾黏分離
Adhesiolysis in a Patient with Severe Intra-abdominal Adhesions Using Different Perspectives of Laparoscopy

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論文發表方式：
影片展示

論文歸類：
內視鏡

Abstract

Background

For patients with severe intra-abdominal and pelvic adhesions, a minimally invasive surgery, while offering limited visibility through a trocar, necessitates meticulous exploration from various angles to gain comprehensive insights.

Case

We reported a 35-year-old female with severe intra-abdominal adhesions, who previously underwent two cesarean sections and presented with recurrent pelvic inflammatory disease, peritonitis, and chronic lower abdominal pain. The patient asked for adhesiolysis to alleviate the associated pain.

In this video, we demonstrate a step-by-step dissection of intra-abdominal adhesions from different quadrants and perspectives. The guiding principle of adhesiolysis is to dissect the finest adhesions devoid of vascular structures while maintaining the intra-abdominal pressure, utilizing the technique of traction and counter-traction.

We will exhibit intraoperative images from various angles within the abdominal cavity and the positioning of the extracorporeal trocars.

After the operation, the patient recovered well, despite temporary bloating for approximately three days. The drainage tubes were removed on the third day of hospitalization, and the patient was able to consume a liquid diet. One week after discharge, she felt that the chronic pain in her abdominal cavity had significantly reduced.

Conclusion

This surgical video emphasizes the importance of multi-angle analysis in managing severe intra-abdominal adhesions, which may provide surgeons with a 3D visualization of intra-abdominal adhesions in their minds. It highlights that traditional open surgery may not always be necessary, which is also the essence of minimally invasive surgery.

稿件編號：V9 臨時稿件編號： 1039	達文西第三隻手臂在子宮內膜癌手術時的運用 The 3th endowrist arm use in robotic staging of endometrial cancer 鍾佳翰 [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	Here we present a video of our technique of robotic staging surgery of endometrial cancer. In addition to having 3D stereoscopic vision, the most important feature of the robotic surgery is its endowrist functionality. Particularly, having a third endowrist to assist the surgical physician allows for reduced reliance on assistant when using the third left arm for traction and counter-traction during surgery, enabling more effective, safe, and stable procedures. Compared to conventional laparoscopy, another advantage of the robotic surgical system is its significantly wider range of angles of endowrists. This enables surgeons to adeptly handle difficult angles during suturing or cauterization. With the addition of the third endowrist, almost all areas within the surgical field can be effectively sutured or cauterized. Additionally, the instruments on the endowrist can be interchanged during surgery. In other words, surgeons can use different endowrists for suturing, cutting, or cauterizing to achieve various surgical tasks. Performing pelvic lymph node dissection requires a significant focus on the surgical field. Restricted visibility could potentially affect the ureter or other pelvic vessels. We use a 2-0 Prolene straight needle for traction of the peritoneum concurrently enhances the clarity of the surgical field and reduces the potential damage to surrounding tissues. We alternate between sharp dissection and blunt dissection techniques to avoid injuring nearby vessels, This technique is particularly crucial when performing para-aortic lymph node sampling.

稿件編號：V10 臨時稿件編號： 1261	抽吸沖洗器械剝離組織技術應用於單孔腹腔鏡子宮內膜異位瘤手術 Stripping technique using suction irrigation instrument in single port laparoscopic surgery for endometrioma 洪詠筑[1] 李光晏[1] 楊恬欣[1] 童寶玲[1] 台大醫院婦產部[1]
論文發表方式： 影片展示 論文歸類： 內視鏡	Objectives: Ovarian stripping with good ovarian function preservation is a key step in fertility sparing laparoscopic surgery for endometrioma. Such technique could be well performed in single-port laparoscopic surgery for endometrioma. Materials and Methods: A 32-year-old, G0P0, unmarried, woman was suffered from abdominal distension for four months. She visited a local medical department specializing in gastroenterology 2 months ago, and her panendoscopy and colonoscopy were found to be normal. A computed tomography (CT) scan revealed a right ovarian multi-cystic tumor with homogeneous content, measuring up to 16 cm x 16 cm. She was referred to our hospital and transabdominal sonography confirmed the ovarian tumor. No solid components were found in the tumor and the ovarian tumor was scored as a low malignancy rate based on simple rules. A four-channel system single-port laparoscopic right oophorocystectomy was performed. During the procedure, a 5-mm camera, two atraumatic grasping forceps, and a suction irrigation device were used for ovarian cyst stripping. The suction irrigation instrument could apply gentle but powerful traction force for cyst wall pealing, and simultaneous endometriotic fluid suction to create clear vision of the cyst layer. The operative time was 76 minutes, and the estimated blood loss was less than 30 cc. There were no complications and the patient was discharged smoothly on the second day of the operation. Results: The patient is now under regular outpatient department follow up. No recurrence is noted within 1 year. Conclusion: Surgical modification by stripping technique has emerged as a key approach to preserve ovarian function, in addition to the aim of reducing recurrent rates. Our technique of ovarian cyst stripping using a suction irrigation instrument could provide gentle but effective ovarian cyst stripping with good ovarian function preservation during single-port surgery.

稿件編號：V11

臨時稿件編號：
1259

針對臨床上疑似重度腹腔內沾黏，經自然孔洞內視鏡協助下進行腹部穿刺套管
Transabdominal trocar insertion for patient with clinically suspected severe intra-abdominal adhesion under direct vision of laparoscopy through posterior colpotomy.

王錦榮 [1] 林杰進 [1] 林偉力 [1] 吳凱筠 [1]
林口長庚紀念婦產科 [1]

論文發表方式：
影片展示

論文歸類：
內視鏡

Complications arising from laparoscopy are often related to the initial entry into the abdomen. Life-threatening complications include injury to viscera or vasculature. These complications may occur during various procedures, including Veress needle insertion, creation of a pneumoperitoneum, primary trocar insertion, or even the Hassen method. They pose challenges and risks, especially when dealing with individuals with obesity and a history of laparotomy surgery. To avoid injuring the bowel adhered to the anterior abdominal wall, several alternative abdominal entry methods have been developed, such as the Palmar point, Lee-Huang point, and others. However, there is still a minimal risk for those with previous laparotomy wound cross the umbilical wound or for surgeons with less experience.

Posterior colpotomy has been one of the mainstay entries for laparoscopic surgery. It has been used for v-NOTES hysterectomy, adnexal surgery, draining pelvic abscesses, and more. While avoiding abdominal incisions, v-NOTES allows for excellent visualization of the abdominal cavity. It ensures that there are no bowel adhesions beneath the umbilical wound before making a transabdominal entry and provides direct vision for trocar entry. Posterior colpotomy may be contraindicated for individuals with severe endometriosis at the rectovaginal septum and severe adhesions.

The video demonstrates the steps of posterior colpotomy-assisted abdominal entry of the trocar under the direct vision of laparoscopy, as well as pre-operative evaluation for posterior colpotomy accessibility.

稿件編號：V12 臨時稿件編號： 1190	達文西經陰道自然孔行困難的全子宮切除術 Robotic vNOTES for complicated hysterectomy 林詠涵[1] 莊斐琪[1] 楊采樺[1] 吳昱靜[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 Vaginal natural orifice transluminal endoscopic (vNOTES) is a trend in minimally invasive surgery. Vaginal total hysterectomy(VTH) has benefits of shorter operation time, less pain, less hospitalization, rapid recovery and least amount of complications. vNOTES as a rising technique is an alternative technique to overcome some limitations of VTH in conditions as non-prolapse uterus, obesity candidates, and enlarged uterus. Furthermore, robotic platform with wristed instruments and stable vision provides a more safety manipulation in the vaginal canal. Methods Herein we will present a surgical video about robotic vNOTES hysterectomy in difficult situations. Results In cases with large-sized uterus, pelvic adhesion, and/or narrowed vagina, robotic instruments provide add-on advantages to traditional vNOTES hysterectomy. Conclusion Robotic system is an essential tool to assist vNOTES procedures in difficult hysterectomy.

稿件編號：V13

臨時稿件編號：
1072

利用 30 度腹腔鏡於單孔手術中處理嚴重膀胱沾黏與腹壁沾黏之技巧

Tips of lateral approach of 30-degree scope during single port laparoscopic surgery of severe adhesion between uterus, urinary bladder and abdominal wall.

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論文發表方式：
影片展示

論文歸類：
內視鏡

Objectives: To demonstrate the tips of using 30-degree scope during single port laparoscopic surgery to find clear margin between adhesion.

Methods: Dense adhesion between organs is a challenge during operation. Dissection adhesion band directly leads to bleed easily. We will provide two typical cases to show advantage of lateral approach of 30-degree scope during single port laparoscopic surgery. Case1 was a 51 y/o female, G0, having menorrhagia, dysmenorrhea and anemia (Hb: 7 g/dl) for years. She had an enlarged uterus with multiple myomata and a right ovarian endometrioma. Dense adhesion between urinary bladder and anterior uterine wall was noted. Case2 was a 42 y/o female, G1P1 (C/S), having a submucosal myoma (type3) at post wall about 9*7 cm in size. Dense adhesion between uterus, anterior abdominal wall and urinary bladder was observed accidentally during operation.

Results: Both cases were noted blurred margin between adhesive organs. We tried to dissect centrally in the beginning but failed due to persisting bleeding. Herein, we took advantage of 30-degree scope, approaching the adhesive boundary laterally after opening peritoneum. It made sharp and blunt dissection of adhesive band easier and avoid complication of ureter injury.

Conclusion: The 30-degree scope using during single port laparoscopic surgery makes surgeon identify the adhesive boundary laterally. Using 30-degree scope to rotate visual field could make surgery safer and easier.

稿件編號：V15 臨時稿件編號： 1091	腹腔鏡子宮頸肌瘤切除合併子宮頸管重建 Laparoscopic cervical myomectomy and reconstruction of endocervical canal 停寧萱[1] 丁大清[1] 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 Cervical myoma accounts for 0.6 percent of all uterine fibroids. Performing laparoscopic cervical myomectomy is often a technical challenge for gynecologists in the narrow operative field, with possible injuries to surrounding pelvic structures, such as ureters, significant hemorrhage, and a complex repair of the big cavity. This video reviews techniques to repair the cervical canal when performing a laparoscopic cervical myomectomy. Patient and Methods This is a 40-year-old female, P0AA1, with chief complaints of menorrhagia for four months. Transvaginal ultrasonography showed cervical myoma 4.5 x 3.2cm. A laparoscopy cervical myomectomy was arranged. During the surgical procedure, no uterine manipulator was inserted. Diluted vasopressin (1:50) was injected into the serosa of the myoma. The myoma was exposed by unipolar excision of serosa and secured by the myoma screw. However, after cervical myomectomy, the cervical canal was exposed. Therefore, we inserted a #8 Foley catheter from the cervical external os under laparoscopic vision. The cervical canal was reconstructed using 1-0 vloc suture, followed by the approximation of the myometrium and serosa. Result Total surgical time was 143 minutes, and the blood loss was 125ml. Intrauterine foley was removed postoperative day 3. The postoperative course was uneventful. Conclusion Laparoscopic cervical myomectomy is a challenging technique. The cervical myoma cavity might expose the cervical canal. Upon exposure to the cervical canal, the method of reconstruction we demonstrated is feasible.

稿件編號：V16 臨時稿件編號： 1169	以腹腔鏡無血「人魚生產」及子宮角切除治療子宮角外孕：案例報告 Laparoscopic Bloodless En Caul Delivery of a Cornual Pregnancy Followed By Cornual Resection: A Case Report 李佾潔 [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 Cornual pregnancies are considered rare, accounting for approximately 1% of all ectopic pregnancies. The diagnosis can be challenging, with a higher risk of complications such as rupture, resulting in life-threatening hemoperitoneum. Surgical treatment may also be complicated by the tendency for intraoperative blood loss. Preemptive ligation of uterine vessels is a viable option to prevent bleeding and facilitate the enucleation of the ectopic pregnancy, as well as the repair of the affected cornu. Patient and Methods Comprehensive temporary ligation of uterine feeding vessels enables a bloodless procedure for the laparoscopic treatment of cornual pregnancy. En caul delivery was performed, and gestational tissue removal was precise and thorough in such settings. The cornual resection and multiple-layered repair were uneventful. Results By comprehensive temporary ligation of uterine feeding vessels, a blood-less procedure can be achieved to treat cornual pregnancy laparoscopically. En caul delivery was done and gestational tissue removal was precise and thorough in such settings. Uneventful cornual resection and multiple-layered repair were performed. Conclusions Laparoscopic cornual resection proved to be a safe and effective option for treating cornual pregnancy in the described patients. Bleeding control before cornuostomy is crucial to establishing a customizable circumstance with more subsequent surgical options.

稿件編號：V17

臨時稿件編號：
1197

連續螺旋縫合術於腹腔鏡子宮肌瘤切除術之應用

A novel procedure: continuous barbed purse-string suture during laparoscopic myomectomy

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論文發表方式：
影片展示

論文歸類：
內視鏡

Study Objective: This study aims to demonstrate a novel purse-string type closure of myometrium in laparoscopic myomectomy. It is intended to facilitate myometrial defect closure, making it more accessible for surgeons and reducing operation time.

Background: Traditional multiple-layer suturing for myometrial closure during laparoscopic myomectomy demands advanced technique, precise instrument handling, and a limited approach angle . However, a single port setting with limited space elevates the challenge of closure of the myometrium. Continuous barbed purse-string suture provides an effortless method of closure of the myometrium. Here, we present several case reports that applied continuous barbed purse-string closure on myometrium closure during laparoscopic myomectomy.

Design: A comprehensive video demonstrating the stepwise technique of purse-string closure for uterine defects.

Setting: We demonstrated the novel closure of intramural, FIGO classification type 4, uterine myoma through laparoscopic myomectomy at the National Taiwan University Hospital, Hsin-Chu branch. Clinical data, intraoperative images, and video were retrieved from the patient’s record.

Intervention: Laparoscopic myomectomy was performed for a 34-year-old woman with lower abdominal pain. Preoperative ultrasound showed an 8.8 cm type 4 myoma. After the extraction of myoma by enucleation, the uterine defect was well-defined as a bag shape. A number 1-O V-LocTM suture (Medtronic, New Haven, CT, USA) was introduced from the left abdominal area. Then the base of the uterine myoma defect was sutured transversely and passed through the myometrium with a continuous purse-string route. During the closing uterine defect, the suture needed to be tightened up and moved in a spiral back pattern to make sure all the dead space was closed. The superficial layer of the uterine incision is closed with 1-O Vicryl(Ethicon Inc, Somerville, NJ, USA).

Conclusion: Continuous barbed purse-string suture seems to be an ideal technique for dealing with laparoscopic myomectomy. It provided a better accessible approaching angle and reduce the operation time. Besides, our novel procedure theoretically reduced the death space, comparing with single layer continuous suture. The purse-string uterine suture technique had been reported in the closure of myometrial defect during cesarean section with significantly lower rate of scar defect . In summary, the novel continuous barbed purse-string suture is a feasible technique of uterine closure.

Reference
1. Te Linde's Operative Gynecology 13th, p384
2. Halouani A, Dimassi K, Ben Mansour A, Triki A. Impact of purse-string uterine suture on scar healing after a cesarean delivery: a randomized controlled trial. Am J Obstet Gynecol MFM. 2023 Jul;5(7):100992.

稿件編號：V18 臨時稿件編號： 1291	單孔腹腔鏡卵巢囊腫切除術 於嚴重骨盆腔沾黏有訣竅 Tips and Tricks for Ovarian Cystectomy in Severe Pelvic Adhesion during Single Port Laparoscopic Surgery 林子涵[1] 楊恬欣[1] 李光晏[1] 童寶玲[1] 國立臺灣大學醫學院附設醫院[1]
論文發表方式： 影片展示 論文歸類： 內視鏡	Objectives: Severe pelvic adhesion can be challenging for minimally invasive surgery. We demonstrated a comprehensive way of handling such condition using single port laparoscopic surgery. Materials and Methods: A 44-year-old, gravida-2-para-1-abortion-1, woman was suffered from intermittent lower abdominal pain for two years. She was diagnosed with uterine myoma, adenomyosis and endometrial polyp, and received a hysteroscopic polypectomy 5 years ago. Unfortunately, the operation was complicated with pelvic abscess formation and she was treated with antibiotics. Laparoscopic hysterectomy was performed one month later, but was converted to abdominal surgery due to severe pelvic adhesion. A 8.8 cm lobulated cystic lesion origin from left adnexa was found by Computed tomography (CT) in 2021. The followed-up transvaginal sonography (TVS) showed that the cystic lesion enlarged up to 10.6*6.5 cm, and was multiloculated with hypoechoic content and thin septum. No solid components were found in the pelvic cysts. Single-port laparoscopic bilateral salpingectomy, cystectomy and adhesiolysis was performed. During the procedure, a transumbilical 2-cm ultraminilaparotomy was made and a four-channel single-port system was setup. A 5-mm camera, a LigaSure™ vessel sealing device, an atraumatic grasping forceps, and a suction irrigation device were applied for adhesiolysis. The cul-de-sac was completely obliterated by omentum, sigmoid colon and the right adnexal cyst. Key steps of performing cystectomy during pelvic adhesion were: larger cysts (>5cm) are better candidates for cystectomy than smaller ones; dissect from the pelvic side wall toward medial side; identify and locate the ureter; dissect the colon from the adnexal cysts using coagulation and cutting function from LigaSure™ vessel sealing device; prevent rupture of cysts until the end of dissection; remove as much cystic capsule as possible; and lastly, application of effective anti-adhesive materials might be necessary. We showed our video utilizing 4DryField® PH(4DF). Results: The operation procedure was uneventful with the operative time was 95 minutes and the blood loss was less than 50 ml. Postoperative recovery was smooth and the patient was then under regular outpatient follow-up without abdominal pain anymore. Conclusion: Single port laparoscopic adhesiolysis and ovarian cystectomy is safe and feasible even in patient with severe pelvic adhesion.

稿件編號：V19 臨時稿件編號：1118	針對陰道與低位直腸深部子宮內膜異位症病灶 施行腹腔鏡部分陰道切除與低位直腸手工盤狀切除縫合之個案報告 Laparoscopic partial vaginectomy and rectal manual disc excision for a case with advanced posterior DE (deep endometriosis) involving vagina and low rectum 孫仲賢[1] 侯詠齡[1] 李佾潔[1] 方俊能[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	Background: Posterior DE (deep endometriosis) involving the uterosacral ligament (USL), torus uterinus (or retrocervix), and rectal serosa is quite common in patients with stage IV endometriosis. DE involving vagina and lower rectum is relatively rare, and possesses special surgical concern. For lower rectal lesions, bowel segmental resection and re-anastomosis may carry relatively high risk of anastomosis failure. Concomitant partial vaginectomy in these kind of cases may also increase the risk of future recto-vagina fistula. In this video, we will demonstrate a case with advanced pelvic endometriosis involving USL, retrocervix, upper vagina, and low rectal lesions less than 6 cm from the anal verge. Materials & methods: Surgical video from a case with advanced pelvic endometriosis involving USL, retrocervix, upper vagina, and low rectal lesions less than 6 cm from anal verge was reviewed and edited. Results: The distorted pelvic anatomy was restored to normal first by careful and systemic adhesiolysis, making use of the retroperitoneal spaces (paravesical, Lazko and Okabayashi pararectal, peri-rectal, rectovaginal spaces). DE lesions were mapped by visual (both white light and ICG) and tactile control. Posterior DE lesions over bilateral USL & retrocervix area were excised first. Partial vaginectomy was then performed, and the vagina wound was re-approximated with barbed suture carefully. The low rectal lesions were shaved first, under the guidance of ICG enema. However, enterotomy still happened due to the deep lesions infiltrating into the rectal mucosa layer. The excision of low rectal lesions was then converted to manual large disc excision. The balloon of pre-inserted rectal Foley catheter could be clearly seen. The low large rectal defect was then repaired in 2 layers transversely. Air leakage test was performed to confirm the integrity of bowel wall. Interceed and omentum patch was covered over rectal lesions, to decrease the potential of future recto-vaginal fistula. The patient recovered well after the surgery. Conclusions: For patients with advanced DE lesions involving vagina and low rectum, laparoscopic partial vaginectomy and rectal manual disc excision is feasible and safe.

稿件編號：V20

臨時稿件編號：
1178

深部浸潤子宮內膜異位的手術技巧，以子宮全切除為例
Techniques in surgery for severe deep endometriosis, a case of patient underwent hysterectomy

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論文發表方式：
影片展示

論文歸類：
內視鏡

Aims:
To demonstrate the advantages of laparoscope in treating deep endometriosis patient, and present excision techniques in a complete cul-de sac obliteration.

Materials, Setting and Methods:
We present our surgical video of a 51-year-old female, who suffered from dysmenorrhea and menorrhagia for years. Adenomyosis and bilateral endometrioma was diagnosed. Patient tried hormone therapy first. However, due to unresolved symptoms and treatment intolerable, and no improvement of image and tumor markers as well, the patient decided to receive laparoscopic hysterectomy and bilateral salpingo-oophorectomy and deep endometriosis excision.

Results:
As we approached inside her abdomen, there was severe adhesion between cul-de-sac, bilateral endometrioma and rectum. The AFS score accounts for 120(stage 4). We identify ureters and then perform oophorectomy first to increase visualization. We then develop the ureteral tunnel and dissect rectovaginal space to restore the anatomy. Deep endometriosis nodule excision is also done. Hysterectomy and bilateral salpingo-oophorectomy then is smoothly performed without complication.

Conclusion:
Hysterectomy and bilateral salpingo-oophorectomy is a definite treatment for deep endometriosis. The organs involved in deep endometriosis include bladder, rectum and ureters. Facing complete obliteration, the techniques demonstrate in this video, such as artificial rupture of endometrioma, development of ureteral tunnel/rectovaginal space/vesicovaginal space, can provide safe ways to dissect endometriosis and hysterectomy.

稿件編號：V21

臨時稿件編號：
1287

針對重度骨盆子宮內膜異位症的系統性手術方式
Systematic approach for unravelling frozen pelvis caused by advanced pelvic endometriosis

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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

Introduction:
Endometriosis surgery, especially those dealing with frozen pelvis and deep infiltrating endometriosis (DE) is among the most difficult gynecological laparoscopic surgeries. The distorted anatomy, multi-organ involvement, and diffuse tissue fibrosis are all factors contributing to surgical difficulties and potential complications. In this video, we will demonstrate the systematic approach method for a case with severe pelvic endometriosis, with dense and diffuse pelvic adhesion, with right ovarian large endometrioma, with posterior DE lesions over bilateral ovarian fossa, uterosacral ligaments (USL), retrocervix, rectovaginal septum, and rectal serosa.

Material & methods:
Patient's clinical data and surgical videos were collected and edited.

Results:
For frozen pelvis with obliterated posterior CDS induced by advanced pelvic endometriosis, surgery was performed in a systemic way. First, identify the pelvic ureter, and dissect the ovarian fossa to lift up the adnexa away from the USL, and separate the ovarian ligament away from the USL. Then dissect the peri-rectal space and develop rectovaginal space. After preparing the surrounding spaces, we perform adnexal surgery following by ovarian suspension. For posterior compartment DE, we begin with ureterolysis, dissect pararectal space, skeletonize the retroperitoneal structures, making resection of all DE lesions over USL, ovarian fossa, retrocervix, and rectovaginal septum safer.
By such systematic approach, the surgery was completed without major complications. The patient recovered well.

Conclusions:
Cases with severe pelvic endometriosis and frozen pelvis can be safely and effectively operated in a systematic way.

稿件編號：V22

臨時稿件編號：
1050

腹腔鏡手術前被誤診為卵巢畸胎瘤的子宮脂肪平滑肌瘤
Uterine lipoleiomyoma misdiagnosis as an ovarian teratoma before laparoscopy

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論文發表方式：
影片展示

論文歸類：
婦癌

Introduction: Lipoleiomyoma is a rare benign neoplasm of uterus. The overall incidence ranges from 0.03% to 2.9%. About 80% are postmenopausal women. The amount of adipocyte and smooth muscle cell can be variable. The pathogenesis is still unclear, and symptoms just like uterine fibroids, which are related to their location and size. Under image study, ultrasound might appear as heterogeneous or hyperechoic with a surrounding hypoechoic ring, which was considered as a layer of myometrium surrounding the fatty tissue. CT and MRI demonstrate fat component after measurement of intensity of signal, and this might misdiagnosis as ovarian teratoma if atrophic or invisible ovaries after menopause. Diagnosis of lipoleiomyoma is only based on surgical removal and pathology checkup.

Case Report: This is a 73 year-old woman, gravida 0, with thyroid papillary carcinoma after total thyroidectomy in 2013. After surgery, subsequent radioactive Iodine-131 therapy was started thereafter. During her annual PET/CT scan follow-up, a pelvic mass, size was approximately 6cm, with mild FDG-18 radio-isotope uptake, and was judged as a teratoma . Thus, she was referred for evaluation and management. Tumor marker, such as CA-125, CEA, and SCC, were all within normal limits. Laparoscopic right salpingo-oophorectomy was carried out on April 21, 2022. During peritoneal inspection, both bilateral adnexal regions appeared normal and atrophic. There was a retroperitoneal tumor located inside uterine-vesicle space. After peritoneal incision at anterior cul-de-sac, a solid, yellowish color tumor was found and removed completely. Final pathology reported a benign lipoleiomyoma. Post-operative recovery was smooth and uneventful.

Conclusion: To differentiate the lipoleiomyoma from teratoma is a diagnostic challenges, even after advanced image study such like CT scan, MRI or PET/CT scan. Surgical excision with pathology checkup is still the gold standard for such difficult case.