

稿件編號：OE02	<p>達文西機械手臂輔助肌瘤切除術與腹腔鏡子宮肌瘤切除術之回溯性比較 Comparison of Robotic and Laparoscopic Myomectomy: A Retrospective Study</p>
臨時稿件編號： 0314	<p>張路得<sup>1</sup> 王毓淇<sup>2</sup> 溫國璋<sup>1,3</sup> 賴鴻政<sup>1,3</sup> 雙和醫院婦產部<sup>1</sup> 三軍總醫院婦產部<sup>2</sup> 台北醫學大學婦產學科<sup>3</sup></p>
論文發表方式： 口頭報告	<p>Objective Uterine myoma was a common benign gynecological disease, and the woman suffered from the symptoms with menorrhagia, urinary frequency, infertility, compression symptoms. Myomectomy is the only choice for fertility preservation in reproductive age, and minimally invasive surgery is the main trend in these decades. In past literature comparing robotic and laparoscopic myomectomy, the reports showed that the operative time of robotic myomectomy is longer than laparoscopic myomectomy, and the short clinical outcome is similar. We accumulated 117 cases of laparoscopic myomectomy and 122 cases of robotic myomectomy since the institution imported a robotic platform in 2014. We find different results than the previous review. In addition, we classified the myoma type by FIGO classification now, but the classification lacks the association with clinical outcome. We presume to modify a new myoma score that correlated with myoma characteristics and clinical outcome.</p>
論文歸類： 內視鏡	<p>Method A retrospective study of 239 cases performed robotic myomectomy 122cases and laparoscopic myomectomy 117 cases from January 2014 and December 2019 in Shuang-Ho Hospital. Robotic surgery was performed using the da Vinci S system (Intuitive Surgical, Inc., Sunnyvale, CA). Data included age, BMI, myoma characteristics (size, type, location, number, weight), pathologic finding, operative time, docking time, console time, blood loss, complications, and hospitalization length. The data were analyzed using R statistical software version 4.02.</p> <p>Results Patients with infertility symptom performed more in robotic-assisted myomectomy with a statistically significant difference. Myoma number mean 2.0 in LM and mean 3.2 in RM( P &lt; 0.05), the intramural type was dominant in RM (38% in LM, 62% in RM), and posterior wall myoma(39.1% in LM, 60.9% in RM), cervical myoma( 0% in LM, 100 % in RM)was also dominant in RM. Myoma number, type, location were the statistically significant difference, and size and pathology were not statistically significant. There was a statistically significant difference in surgical time (184.7 vs. 163.2 mins), blood loss, and no significant difference in hospital day. The multivariate linear regression revealed that the robotic approach, myoma number, and myoma size are significant associated with operation time.</p> <p>Conclusion The surgeon chooses the robotic myomectomy in the case of infertility concern, multiple myomas, intramural type myoma, posterior myoma, and cervical myoma. Robotic myomectomy's operative time is shorter than laparoscopic myomectomy, and the robotic approach is an important factor associated with operative time in multivariate linear regression. Robotic platforms tend to perform the more complicated myomectomy with shorter operative time.</p>

稿件編號：OE03	<p>門診子宮鏡子宮內膜瘰肉切除：使用電燒與否之復發率                  Recurrence of endometrial polyps after office hysteroscopic polypectomy by mechanical or electrosurgical resection</p>
臨時稿件編號：0332	
論文發表方式：口頭報告	<p>Endometrial polyp recurrence is defined as the growth of an endometrial polyp(s) at the same location it was resected during the previous hysteroscopic manipulation; determined by either subsequent ultrasonography or hysteroscopy at a later time period.</p>
論文歸類：內視鏡	<p>吳凱筠<sup>1</sup> 翁瑄<sup>1</sup> 林玉珊<sup>1</sup> 王錦榮<sup>1</sup> 趙安琪<sup>1</sup>                  林口長庚醫院婦產部<sup>1</sup></p> <p>Objective: To compare the recurrence rate of endometrial polyps after office hysteroscopic polypectomy by mechanical or electrosurgical resection.</p> <p>Study Design: This was a retrospective study that took place at a tertiary hospital from October 2018 to May 2020. A total of 271 patients were enrolled.</p> <p>Interventions: Hysteroscopy with a 2.8-mm optic and a 3.9- x 5.9-mm sheathed operative hysteroscope, without local anesthesia. The diagnostic evaluation was followed by polyp resection, by either mechanical or electrosurgical instrumentation.</p> <p>Measurements:                  Primary Outcome: Effectiveness, operation time                  Secondary Outcome: Recurrence</p> <p>Results:                  Amongst the 271 patients enrolled, 230 patients underwent mechanical resection, while 38 patients underwent electrosurgical resection of endometrial polyps. Of the patients who received mechanical resection, 20 (8.69%) were found with polyp recurrence by either ultrasonography or hysteroscopy. Those who received electrosurgical resection, 3 (7.89%) were found with polyp recurrence.</p>

稿件編號：OE04	<p>腹腔鏡乾箱環境下，以摺紙作為基礎手眼協調訓練及評量的信度、效度研究</p>
<p>臨時稿件編號： 0236</p>	<p>Developing an Origami Box-folding Exercise and an Objective Structured Assessment of Technical Skills Tool for Comprehensively Enhancing and Evaluating the Ability of Laparoscopic Hand-eye Coordination in a Dry Box Environment</p> <p>郭信宏<sup>1</sup> 林偉力<sup>1</sup> 李奇龍<sup>1</sup> 黃寬仁<sup>1</sup> 顏志峰<sup>1</sup> 王錦榮<sup>1</sup> 吳凱筠<sup>1</sup> 周宏學<sup>1</sup> 謝明儒<sup>2</sup> 盧佳序<sup>1</sup> 林口長庚醫院婦產部<sup>1</sup> 林口長庚醫院外科部<sup>2</sup></p>
<p>論文發表方式： 口頭報告</p>	<p>Background: The origami box-folding exercise trains abilities as “tight or loose grab in a single instrument”, “ambidexterity between two hands”, “using the grasp to open space”, “how to rotate the target tissue”, “control the power to hold the paper” and “keep the integrity of the tissue”. (<a href="https://reurl.cc/m9axpl">https://reurl.cc/m9axpl</a>, video narration 5:39-8:37)</p>
<p>論文歸類： 內視鏡</p>	<p>In our experience, the training is optimized for building comprehensive levels of hand-eye coordination.</p> <p>The exercise is measured in a format of objective structured assessment of technical skills (OSATS), a validated assessment tool evaluates not only the procedures through a procedure-specific checklist (PSC) but also the global operative score through a global rating scale (GRS).</p> <p>Objective: This study aimed to develop a standardized origami box-folding exercise and the associated verified OSATS tool.</p> <p>Study Design: IRB was approved by Chang Gung Medical Foundation Institutional Review Board, Project No.201900171B1. Two groups were compared. Experienced group included 17 participants (level from 2nd -year resident to attending physicians) from the pre-congress workshop of Taiwan Association for Minimally Invasive Gynecology in 2019; whereas non-experienced group recruited 20 4th -year medical students from a laparoscopic workshop curriculum at Chang Gung University in 2020. In the workshop, an only one trainer demonstrated the origami exercise firstly. A paper was fold in the shape of the instructed paper-box, unfolded and placed inside a box simulator by hands. Then the paper-box was refolded by laparoscopic instruments under direct visualization. (<a href="https://reurl.cc/m9axpl">https://reurl.cc/m9axpl</a>) All 37 participants shadow the procedures with a time limit of 5 minutes. All the exercises were video-recorded and scored by two experienced evaluators based on the OSATS tool. The exclusion criterion was the failure of video-recording. Statistics was calculated SPSS, Windows version 25 (SPSS Inc., Chicago, IL).</p> <p>Result: One trainee in experienced group was excluded due to collapse of the video. Data from 36 participant was analyzed. In reliability, Kuder-Richardson Formula 20 in PSC was 0.928 and Cronbach's alpha in GRS was 0.925. Pearson Correlation between PSC and GRS was 0.871; whereas Intraclass Correlation between two raters in PSC and GRS was 0.984 and 0.941, respectively. The overall correlation coefficient was 0.979. As for Factor Analysis, Kaiser-Meyer-Olkin resulted in 0.883; p-value in Bartlett's test was</p> <p>Conclusion: Origami box-folding exercise eases to prepare and enhance advanced laparoscopic hand-eye ability. The OSATS tool has high reliability and validity. The kit is developed for comprehensive assessment and educational feedback of trainees.</p>

稿件編號：OE07	<p>子宮肌瘤或子宮肌腺症於海扶治療後的手術介入</p> <p>Surgical interventions for patients with uterine myomas or adenomyosis after HIFU treatments</p>
臨時稿件編號：0053	<p>張至婷<sup>1</sup> 莊蕙瑜<sup>1</sup> 林冠伶<sup>2</sup> 龍震宇<sup>1</sup> 鄭丞傑<sup>3,4,1</sup></p> <p>高雄醫學大學附設中和紀念醫院<sup>1</sup> 高雄市立大同醫院（委託高醫經營）<sup>2</sup> 台北秀傳醫院<sup>3</sup> 彰化秀傳醫院<sup>4</sup></p>
論文發表方式：口頭報告	<p>Objective</p> <p>We aimed to investigate surgical intervention rate and the clinical characteristic of the patients who underwent surgery after high intensity focused ultrasound (HIFU).</p>
論文歸類：內視鏡	<p>Methods</p> <p>From April 2015 to April 2020, a total of 700 patients with leiomyomas and adenomyosis were included for treatment using HIFU at Kaohsiung Medical University Hospital. Patients who underwent an operative procedure, including hysterectomy or myomectomy, after HIFU were included. We investigated the reason for surgical intervention. Total treatment time, sonication time, average sonication power, and adverse reaction during treatment were recorded. Volume change of uterus and leiomyoma were calculated with MRI and compared before and 3 months after treatment. The evaluation of symptoms improvement was based on the clinical visit, symptom severity scores, and Uterine Fibroid Symptom and Quality of Life questionnaires. If the operative procedure was done at Kaohsiung Medical University Hospital, the weight of the mass, and the histopathologic findings were assessed.</p> <p>Results</p> <p>After follow-up time of 6-60 months, a total of 35 patients had undergone an operative procedure after HIFU and were analyzed. Eleven patients underwent hysterectomy, and 23 patients underwent myomectomy. Four patients had open method myomectomy, 6 underwent laparoscopic myomectomy, and 13 underwent planned hysteroscopic myomectomy. Unplanned re-intervention rate was 3%, and planned surgical intervention rate was 1.8%. Of all patients underwent surgical intervention, 29 were uterine fibroids, and 6 were adenomyosis. The reasons for surgery were an increase in the size of leiomyoma, persistent symptoms, or FIGO type 0-2 submucous myoma after HIFU. The volume of uterus, leiomyomas, and adenomyotic lesion decreased by 26.3%, 24.3%, 46.2% respectively 3 months after treatment. One patient was found to have endometrial cancer incidentally by the hysteroscopy, and staging surgery was performed. One patient who had undergone hysterectomy came out to be leiomyosarcoma. The median interval between HIFU and surgery was 13.8 months.</p> <p>Conclusions:</p> <p>The surgical intervention rate after HIFU treatment for uterine myoma or adenomyosis is comparable with those after laparoscopic myomectomy. The possibility of malignancy should always be alerted for increasing size of leiomyoma after HIFU ablation. For difficult treated HIFU cases, preoperative counselling about the necessary of two sessions of HIFU surgery or combined treatment is needed.</p>

稿件編號：V02	<p style="text-align: center;">雙孔腹腔鏡處理巨大卵巢囊腫的新方法</p> <p style="text-align: center;">A method of laparoscopic treatment of large adnexal cysts – Two ports trocar suction</p>
臨時稿件編號：0091	
論文發表方式：影片展示	Objective: To offer a method to solve the difficulty in laparoscopic management of large adnexal cysts.
論文歸類：內視鏡	<p>Materials: and Methods This is a retrospective study of 45 patients with large (<math>\geq 10\text{cm}</math>) adnexal cysts, managed laparoscopically at one center from October 2016 to October 2019. All the surgeries were performed by an experienced laparoscopic surgeon. Malignancy was excluded before the surgeries according to the sonographic features. Cystectomy or salpingo-oophorectomy was decided according to the age, the sonographic pattern of the cyst and the patients' willing. A 2cm vertical incision was made at the umbilicus, and open laparoscopy method was used to enter the peritoneal cavity. A wound protector was applied with a glove and two trocars being set up. The second wound was made at left abdomen, and a 5mm trocar was inserted. Then the cyst was punctured via the 5mm trocar, and the content of the cyst was then soon aspirated via the air-flow hole of the trocar. Afterward, cystectomy or salpingo-oophorectomy was performed. Data are expressed as mean <math>\pm</math> standard deviation unless stated otherwise.</p> <p>Results and Discussion: One case was excluded due to the method was failed to manage the cyst with many thick septa. The mean of operative duration was <math>52.7\pm 21.3</math> minutes, shorter than other methods. Most estimated blood loss (EBL) was minimum. The pain score on the first post-OP day was <math>2.4\pm 0.8</math>. The average of postoperative hospital stay was <math>1.2\pm 0.5</math> days. No obvious complication was found. The unexpected malignancy rate was 4.5% (2/44), compatible with some previous studies.</p> <p>Conclusion: Trocar suction in laparoscopic management of large adnexal cysts is feasible, and it takes less operative time. This method is limited to the cysts with many thick septa.</p>

稿件編號：V03	<p>在未曾經歷腹部手術的女性使用腹腔鏡處理一個由大腸系膜供應血流的寄生性肌</p>
<p>臨時稿件編號： 0200</p>	<p>Laparoscopic management of a parasitic myoma with mesocolonic blood supply in an abdomen-surgery-naive lady</p> <p>陳楨瑞<sup>1</sup> 楊曜瑜<sup>2</sup> 王功亮<sup>3</sup> 馬偕紀念醫院婦癌科<sup>1</sup> 馬偕紀念醫院婦產部<sup>2</sup> 馬偕醫院台東分院<sup>3</sup></p>
<p>論文發表方式： 影片展示</p>	<p>Background: Parasitic myomas may occur spontaneously as pedunculated subserosal myomas lose their uterine blood supply and parasitize to other organs. Most parasitic myomas are located inside pelvis, and supplied by the vessels from omentum.</p>
<p>論文歸類： 內視鏡</p>	<p>Theoretically it may be iatrogenically created after surgery, particularly surgery using morcellation techniques. Here we would like to present an abdomen-surgery-naive lady who has a parasitic myoma with blood supply from mesocolon of sigmoid colon, underwent a successful laparoscopic management.</p> <p>Case Report: A 45 year-old, para2, female presented in gynecologic clinic of MacKay memorial hospital in Taipei due to an abdominal self-palpable mass for 1 year. This tumor was 8 cm in diameter, located just 4cm below umbilicus and was movable during abdominal palpation. Pelvic examination showed grossly normal external genitalia, cervix and adnexa, but uterine corpus was connected to this sub-umbilical mass. Ultrasonography revealed several uterine solid mass, compatible with myoma, and the biggest one was this palpable mass, in favor of a subserosal, pedunculated myoma. Laparoscopic myomectomy was carried out and a solid mass with blood supply from mesocolon of sigmoid colon, but without any connection to uterine corpus grossly. During resection of the pedicle from mesocolon, massive active bleeding from mesocolon was encountered. Multiple compression suture achieved good hemostasis, without using any extra-pay hemostatic agent. This lady discharged from hospital 2 days after surgery without blood transfusion or any complication.</p> <p>Conclusion: Parasitic myoma in an abdomen-surgery-naive lady is rare, and blood supply from mesocolonic vessel is also rare. Because its pedicle is frequent vascular rich, resection without well preparation sometimes causes massive bleeding which is difficultly controlled. Mature and effective suture technique, vasosuppressin agent or staple technique should always be prepared if such condition is encountered.</p>

稿件編號：V04	<p style="text-align: center;">達文西手臂手術應用於巨大子宮肌瘤</p> <p style="text-align: center;">Interval debulking of myoma during Robotic superhuge broad ligament myomectomy</p>
臨時稿件編號： 0089	
論文發表方式： 影片展示	<p>Robotic myomectomy, a type of laparoscopic myomectomy, is a minimally invasive way for surgeons to remove uterine fibroids. Compared to open abdominal surgery, with robotic myomectomy there will be less blood loss, have fewer complications, have a shorter hospital stay and return to normal activities more quickly.</p>
論文歸類： 內視鏡	<p>However, when the myoma is superhuge size (more than 20 cm in diameter) which fill the whole pelvic cavity and lower abdomen extended to the umbilicus. There is almost no space to enucleate the myoma before decrease of the big mass. The 3d vision and endo-wrist function made it feasible to enter the deep pelvis and control of uterine vessel and dissection of ureter even the myoma size is huge. Here we present a video of our technique by cutting the mass with wound retractor after control of the uterine vessels and enucleate half of the myoma firstly. Then we could proceed to the deep pelvic broad ligament with ureter lateralization. Robotic surgery may take longer and be more costly than traditional laparoscopy, but in this superhuge size, only endowrist function of the robotic arm could dissect the vital anatomic</p>

稿件編號：V05	<p>腹腔鏡輸卵管子宮角吻合術: 可行性與預後的初步評估 Laparoscopic Tubocornual Anastomosis: Its Surgical Feasibility and Outcomes</p>
<p>臨時稿件編號： 0029</p>	
<p>論文發表方式： 影片展示</p>	<p>Research Question: Is there a role for laparoscopic tubocornual anastomosis (TCA) in the era of assisted reproductive technology (ART)?</p>
<p>論文歸類： 內視鏡</p>	<p>Design: A retrospective analysis of fourteen females with identified proximal tubal occlusions and preferences for natural conceptions in a university-affiliated tertiary hospital, between 2011 to 2018.</p> <p>Results(s): Assessment with hysterosalpingogram postoperatively demonstrated a patency rate of 64.2% after TCA. Post-operative natural conceptions resulted in a crude pregnancy rate of 50% and a live birth rate of 28.6%. In which, five (62.5%) of the eight patients with non-patent contralateral tubes had reconstructed, patent TCA tubes; furthermore, three of them conceived successfully. There were two ectopic pregnancies and one early miscarriage. Patients' age and past surgical history did not affect the pregnancy rates in this small series.</p> <p>Conclusion(s): This IDEAL stage 2a preliminary series demonstrated promising results when choosing laparoscopic TCA for women with proximal tubal occlusions and preferences for natural conception. Microsurgical tubal reconstruction, as described here, can be a complementary treatment to ART. Careful patient selection and meticulous techniques are crucial for the success of the procedure. A larger prospective series is mandatory to establish its significance and application in clinical practices.</p>

稿件編號：V06	<p>腹腔鏡全子宮切除併雙側卵巢輸卵管切除暨腹膜寄生性肌腺瘤切除作為終極處理 一罕見腹腔鏡肌瘤切除後併發瀰漫性腹腔內子宮肌腺瘤擴散之病例</p>
<p>臨時稿件編號： 0220</p>	<p>Total laparoscopic hysterectomy with bilateral salpingo-oophorectomy plus resection of diffuse peritoneal parasite adenomyoma for a rare case with recurrent peritoneal adenomyomatosis following laparoscopic myomectomy</p> <p>孫仲賢<sup>1</sup> 方俊能<sup>1</sup> 王元勇<sup>1</sup> 施兆蘭<sup>1</sup> 李侖潔<sup>1</sup> 陳瑞華<sup>1</sup> 陳曼玲<sup>1</sup> 陳宥臻<sup>1</sup> 李宜明<sup>1</sup> 莊國泰<sup>1</sup> 四季台安醫院<sup>1</sup></p>
<p>論文發表方式： 影片展示</p>	<p>Introduction: In those old days when we are still using power morcellator to remove the myomas without protection during laparoscopic myomectomy, some patients may develop parasite myomas. Although most parasite myomas are small and asymptomatic, sometimes these parasite myomas may enlarge and become symptomatic that warrant active treatment. In this video, we will demonstrate a rare case of diffuse intraperitoneal adenomyomatosis (not leiomyomatosis) developed after previous laparoscopic myomectomy. 2nd laparoscopic surgery was performed (laparoscopic myomectomy, parasite tumor resection). Adjuvant hormone suppression was given, but recurrent intraperitoneal adenomyomatosis was noted 3 years after 2nd surgery, gradually enlarged, and at last caused compression symptoms including tenesmus, frequency, and pelvic pain. Total laparoscopic hysterectomy and bilateral salpingo-oophorectomy (TLH +BSO), as well as parasite tumor resection/debulking, was performed later as the final definite surgical treatment.</p>
<p>論文歸類： 內視鏡</p>	<p>Materials and method: Surgical videos of the 2nd and 3rd laparoscopic surgeries were collected and edited, illustrating the serious condition of her intraperitoneal adenomyomatosis.</p> <p>Result: This virgin patient, receiving laparoscopic myomectomy 9 years ago at other hospital, received 2nd laparoscopic surgery for recurrent symptomatic uterine myomas and diffuse intraperitoneal “leiomyomatosis” 5 years ago. Numerous intraperitoneal parasite “myoma” were noted. These tumors were debulked as possible. At this time, all the specimens were removed in the retrieval bag. The pathology of the “parasite myoma” was not leiomyoma, but turned out to be adenomyosis and adenomatoid tumor. Adjuvant hormone suppression was prescribed, but later was stopped by patient herself due to the intolerable side effect. Recurrent intraperitoneal adenomyomatosis was noted soon after, gradually enlarged, and at last caused serious compression symptoms. She received 3rd laparoscopic surgery. Severe intraperitoneal adhesion, with multiple peritoneal tumor seeding (including Morrison pouch, paracolic gutter, mesentery, pararectal area, and even previous laparoscopic trocar site), were noted. TLH + BSO, as well as parasite tumor resection/debulking was performed as the final definite surgical treatment. The patient recovered soon after the surgery. She was informed not to receive any kind of hormone therapy to prevent tumor recurrence, and lived well now.</p> <p>Conclusion: Intraperitoneal leiomyomatosis or adenomyomatosis is a rare but serious complication following laparoscopic myomectomy procedure. Castration (BSO) may be the final solution to prevent recurrent parasite tumor seeding and growing. From this patient’s history, we again learned the importance of contained morcellation during specimen retrieval in laparoscopic myomectomy.</p>

稿件編號：V08	<p style="text-align: center;">腹腔鏡複雜性子宮次全切除、沾黏分離、腹腔內腫瘤切除 Complicated laparoscopic subtotal hysterectomy and enterolysis with intra-abdominal tumor resection</p>
臨時稿件編號：0204	
論文發表方式：影片展示	<p>盧孟涵<sup>1</sup> 義大財團法人義大醫院婦產部<sup>1</sup></p>
論文歸類：內視鏡	<p>We would like to share the video of a case of status post twice endometrioma enucleation and adhesiolysis and then have complicated laparoscopic subtotal hysterectomy and enterolysis with intra-abdominal tumor resection.</p> <p>This is a 44 year-old female with G1P1 (via Cesarean section) who denied systemic disease. She suffered from severe dysmenorrhea and menorrhagia for more than 10 years. She received laparotomy myomectomy, enucleation of left endometrioma and adhesiolysis in 2011. She kept following up and with medication control of her symptoms. Because she still had the relative symptoms of dysmenorrhea and menorrhagia so she received a second surgery of laparoscopic ovarian tumor enucleation and extensive enterolysis in 2014. After the surgery, the Mirena was recommended but patient refused so she just had pain control during menstrual period and regularly follow up. She ever had oral contraceptive pills and Dienogest to control the pain of endometriosis related. During the period, the surgical intervention of laparoscopic total or subtotal hysterectomy was suggested but patient hesitated for a long time and just wanted to have medication control. After more than five years of medication control, she still has symptoms of dysmenorrhea and menorrhagia. The sonography showed enlarged uterus with adenomyosis and increased size of the uterine myomas and elevated CA-125 so the surgical intervention was highly suggested. After discussed with patient, the laparoscopic hysterectomy was arranged. The first finding of operation is Cul-De-Sac total obliteration, right adnexa was densely adherent to right ovarian fossa and posterior wall. After adhesiolysis step by step, the left adnexa was found and also densely adherent to colon and pelvic wall. We also found one left adnexal tumor and need to ruled out ovary or myoma which the tumor was covered by sigmoid colon. We consulted colorectal surgeon who done the enterolysis as possible and resected the intra-abdominal mass completely without sigmoid colon injury. After tumor resection, we done the subtotal hysterectomy and bilateral salpingectomy. The cystoscopy showed intact bladder and bilateral ureteral patency.</p> <p>The patient recovered well and final pathology revealed : 1. leiomyoma and adenomyosis 2. unremarkable fallopian tubes 3. Leiomyoma of the intra-abdominal tumor.</p>

稿件編號：V10	<p style="text-align: center;">合併傳統子宮鏡與碎瘤器治療子宮黏膜下肌瘤 Combined hysteroscopic morcellation and loop resection for huge submucosal leiomyoma</p>
臨時稿件編號：0184	
論文發表方式：影片展示	<p>方郁婕<sup>1</sup> 桂羅利<sup>1</sup> 張基昌<sup>2</sup> 張裕<sup>1</sup> 義大醫院<sup>1</sup> 義大大昌醫院<sup>2</sup></p>
論文歸類：內視鏡	<p><b>Background:</b> Uterine leiomyoma is the most common pelvic tumor in women. Abnormal uterine bleeding is the most common symptom, which is most frequently related to submucosal and intramural myomas. In 2004, the TRUCLEAR hysteroscopic morcellator (THM) was approved as an alternative to monopolar and bipolar resectoscopy for hysteroscopic myomectomy. In our case, we will demonstrate the combination of hysteroscopic loop resection and TRUCLEAR hysteroscopic morcellator (THM) for prolapsed submucous leiomyoma.</p> <p><b>Patient and method:</b> This 37-year-old female, virgin, came to our outpatient department due to palpable protruding mass from vagina in recent months. Gynecologic ultrasound showed adenomyosis and endometrium thickness. Official hysteroscope showed a prolapsed submucosal leiomyoma to vagina.</p> <p><b>Result:</b> We used both hysteroscopic morcellation and loop resection for resection of prolapsed submucosal leiomyoma. There was minimal amount of bleeding, short operating time, and minimal fluid absorption during the operation.</p> <p><b>Conclusion:</b> Hysteroscopic morcellation system still has limitation for leiomyoma resection. We demonstrated the combination of hysteroscopic morcellation and loop resection for submucosal leiomyoma in virgin.</p>

稿件編號：V11	<p style="text-align: center;">利用腹腔鏡進行巨大子宮頸肌瘤挖除時的一些重要手術技巧 Technical pearls of Laparoscopic myomectomy for large cervical myoma</p> <p style="text-align: center;">方俊能<sup>1</sup> 孫仲賢<sup>1</sup> 陳瑞華<sup>1</sup> 李宜明<sup>1</sup> 王元勇<sup>1</sup> 陳曼玲<sup>1</sup> 施兆蘭<sup>1</sup> 李儉潔<sup>1</sup> 莊國泰<sup>1</sup> 高雄市四季台安醫院<sup>1</sup></p>
臨時稿件編號： 0118	
論文發表方式： 影片展示	<p><b>Introduction:</b> Laparoscopic myomectomy (LM) has become the common and standard procedure for managing patients bothered by symptomatic uterine myomas. Although the techniques and procedures of LM are quite straight forward and standardized, “retroperitoneal myoma” (including intraligamental/broad ligament myoma, cervical myoma) possess special technical difficulties. The adjacent important retroperitoneal structures need to be identified and protected during the whole procedure. Cervical myoma brings another important technical issue. The distorted cervical anatomy after myomectomy makes suture repair of the remaining myometrium and cervical stroma extremely difficult and possesses the potential danger of cervical canal obstruction. In this video, we will demonstrate a case with large anterior cervical myoma, treated by LM. The technical pearls will be highlighted and discussed.</p> <p><b>Materials and methods:</b> Surgical videos of a case with large anterior cervical myoma causing acute urine retention undergoing LM were collected and edited. The important adjacent structures were identified and highlighted, and the technical pearls for safe and effective repair for the remaining distorted cervical stroma were illustrated.</p> <p><b>Result:</b> After opening the peritoneum overlying vesico-uterine junction, bladder flap was dissected away, and the huge bulging anterior cervical mass was exposed. Harmonic scalpel was applied, cutting into the bulging mass, identified the correct plane of the myoma capsule, stayed precisely along the plane, and myomectomy was easily completed. Before closing the large cervical myometrium hole, the uterine vessels, distal ureters were carefully identified and dissected away. Bladder flap was further dissected to expose the entire cervix. The precise position of cervical canal was identified by inserting a #12 Hegar dilator along the long cervical canal into uterine cavity under laparoscopic guidance. The Hegar dilator was kept in place during the whole repairing process to prevent cervical canal obstruction or distortion. The distorted remaining cervical stroma tissue was then carefully re-approximated, with special attention not to incorporate the adjacent retroperitoneal structures. After completing the myometrium repair, Hegar dilator was removed and replaced by a #24 Foley catheter, which was left in situ for 10 days. The whole procedure was smooth, with minimal blood loss, and the patient recovered well.</p> <p><b>Conclusion:</b> LM for large cervical myoma possess special technical tricks. By paying special attention to the adjacent retroperitoneal structures, and especially keeping the cervical canal patent, large cervical myoma with marked distorted anatomy can still be managed by laparoscopic approach.</p>
論文歸類： 內視鏡	

稿件編號：V12	<p>以神經牽引測試定位下腹神經並非全然可靠，除非已經徹底分離沾黏分離</p> <p>Identification of Hypogastric Nerve by Nerve Traction Test: Not Always Reliable Unless Adequate Adhesiolysis and Neurolysis</p>
臨時稿件編號：0215	<p>李侑潔<sup>1</sup> 莊國泰<sup>1</sup> 方俊能<sup>1</sup> 陳瑞華<sup>1</sup> 王元勇<sup>1</sup> 李宜明<sup>1</sup> 陳曼玲<sup>1</sup> 施兆蘭<sup>1</sup> 陳宥臻<sup>1</sup> 孫仲賢<sup>1</sup></p> <p>四季台安醫院<sup>1</sup></p>
論文發表方式：影片展示	<p>Introduction</p> <p>Posterior deep endometriosis (DE) involving the uterosacral ligament is the most common form of pelvic DE. Nerve sparing DE excision is essential to preserve the important autonomic nerves and prevent future long term sequela, while the hypogastric nerve, and occasionally the inferior hypogastric plexus, may adhere or even be incorporated to the DE complex. The identification of such nerve fibers within the DE complex is sometimes difficult. Antegrade dissection of presacral area and “contralateral nerve traction test” are useful maneuvers to identify the course of the embedded hypogastric nerves and to differentiate between the nerve fibers and the DE fibrotic bands.</p>
論文歸類：內視鏡	<p>However, the adhesion which is frequently seen in posterior DE may mislead the surgeons if without adequate adhesiolysis. In this video, we will demonstrate several nerve-sparing DE surgical scenarios in which we tried to identify the hidden hypogastric nerves by applying the techniques of nerve traction test.</p> <p>Material and method</p> <p>We herein present a surgical video of the nerve sparing techniques in deep infiltrating endometriosis surgeries. All video clips included are edited from surgeries carried out in our hospital.</p> <p>Result</p> <p>After thorough adhesiolysis, DE surgeries can be safely performed with optimal preservation of important autonomic nerves.</p> <p>Conclusion</p> <p>In our experience, thorough adhesiolysis and neurolysis should be done firstly to explore the route of the hypogastric nerves. The nature of deep endometriosis may mislead the surgeons if otherwise.</p>

稿件編號：V13	<p>利用腹腔鏡進行巨大基底的子宮側壁肌瘤挖除時的一些重要手術技巧          Technical pearls of Laparoscopic myomectomy for large base broad ligament (intraligmental) myoma</p> <p>李宜明<sup>1</sup> 孫仲賢<sup>1</sup> 施兆蘭<sup>1</sup> 方俊能<sup>1</sup> 李侷潔<sup>1</sup>          四季台安醫院<sup>1</sup></p>
臨時稿件編號： 0330	
論文發表方式： 影片展示	<p>Introduction:          Laparoscopic myomectomy (LM) has become the common and standard procedure for managing patients bothered by symptomatic uterine myomas. Although the techniques and procedures of LM are quite straight forward and standardized, “retroperitoneal myoma” (including intraligmental/broad ligament myoma, cervical myoma) possess special technical difficulties. The adjacent important retroperitoneal structures need to be identified and protected during the whole procedure. For broad ligament myomas, just like subserosal myomas, if the connecting part of the myoma base is small (pedunculated), myoma base bleeding after myomectomy can be easily handled by cautery and may not need any suture. However, if the myoma base is wide and deep, or if the base bleeder was difficult to control, effective suture is still mandatory. In this video, we will demonstrate a case with large right broad ligament myoma causing hydroureter, with wide and deep base almost all along from cervical area up to ovarian ligament. Technical pearls will be highlighted and discussed.</p> <p>Materials and methods:          Surgical videos of a case with large right broad ligament (intraligmental) myoma causing obstructive uropathy (hydroureter, hydronephrosis) undergoing LM were collected and edited. The important adjacent structures were identified and highlighted, and the technical pearls for safe and effective repair for the remaining large and deep myoma base alongside the lateral uterine wall were illustrated.</p> <p>Result:          After opening the peritoneum overlying posterior leaf of right broad ligament, the irregular multi-lobulated broad ligament myoma was gradually exposed. Just like other myomas, broad ligament myoma also have “capsules”. Before cutting into the myoma capsule, the course of right ureter was carefully identified. The myomectomy process was proceeded along the precise plane between myoma and capsule, aided by Harmonic scalpel. After complete myomectomy, a large and deep myomertrium wound base was noted alongside the right lateral uterine wall that will definitely demand meticulous suture repair. Before repairing the defect, right ureter and uterine vessels were further dissected, even aided by opening the anterior broad ligament leaf for monitoring the distal ureter course. Several interrupt figure of 8 sutures were applied, to incorporate any potential dead space. The whole procedure was smooth, with minimal blood loss, and the patient recovered well.</p> <p>Conclusion:          LM for large and wide-base broad ligament myoma possess special technical tricks. By paying special attention to the adjacent retroperitoneal structures, large broad ligament myoma causing obstructive uropathy can be safely and effectively managed by laparoscopic approach.</p>
論文歸類： 內視鏡	

稿件編號：V14	改良式腹腔鏡輸尿管膀胱重建術治療下三分之一醫源性輸尿管損傷：一種更簡單的方式與七例病例報告
臨時稿件編號：0174	<p>Outcome of Laparoscopic Modified Ureteroneocystomy in lower third iatrogenic ureter injury during laparoscopic surgery of gynecology: a easier method for repair</p> <p>辜家儀<sup>1</sup> 大林慈濟醫院婦產科<sup>1</sup></p>
論文發表方式：影片展示	<p>Introduction: Iatrogenic ureter injuries are known complications of any gynecologic surgery. The lower third of ureter is most vulnerable laparoscopically at the infundibulopelvic ligament, where it lies deep in the ovarian fossa and at the ureteral canal. Ureteroneocystostomy (UNC) refers to reimplantation of the ureter into the bladder. However, due to reimplantation of ureter in bladder has arisen some issues on vesicoureteral reflux(VUR), many procedure had been introduced in order to prevent this complication such as modified Politano lead better repair, and an extravesical Lich-Gregoir. Some expertise using Boari flap or Psoas hitch for repair. Those procedures were complicated and may need laparotomy for good outcomes. Thus, we are now presenting cases with easier ways of repair using laparoscopic modified ureteroneocystomy method in repairing lower third ureter injuries.</p>
論文歸類：內視鏡	<p>Study Objective: To review the feasibility of laparoscopic repair in cases of ureteral injuries during gynecologic laparoscopic surgery.</p> <p>Design: Retrospective study in between 2017~2019</p> <p>Patients: Patients suffering from iatrogenic ureteral injuries in gynecologysurgery</p> <p>Methods: Seven cases of iatrogenic ureter transections were diagnosed and repaired laparoscopically by surgeon. Repair was done by the help of urologist using cystoscopy to identify the highest level of bladder in order for ureter implantation. The injured ureter was being released from retroperitoneum to achieve the adequate length of ureter implantation. Before implantation, the orifice of ureter was identified and clear urine was seen from orifice. Using laparoscopic assisted, stenting was inserted, transvesical insertion of ureter was closed to bladder wall with letting 1 cm of ureter in bladder and 3-5 suture was done around ureter. The stent in ureter was then removed later in future. After operation, foley was inserted for at least 8 days for ureter healing. After operation, intravenous cystography and kidney echography was performed few months later. Early recognition and treatment of ureteral injuries are important to prevent morbidity. Laparoscopic modified ureteroneocystostomy could be considered in lower third ureter injuries.</p> <p>Pt Surgery Indication Injury Time of recognition Outcome Reflux 1 LAVH + excision of DIE DIE, endometriosis Lt Post OP D11 No hydro IVU(-) - 2 LAVH and LSO and RS and excision of endometriosis at bladder area Lower seg myoma 7.7 x 5.5cm Rt Post OP D3 No hydro IVU(-) No</p>

- 3 LSC RAH+ BPLND+PALND Cervical Ca Rt OP day No hydro -
- 4 LAVH Myoma, fundus 10x7cm Rt Post OP D7 No hydro IVU (-) -
- 5 LAVH Low seg myoma 6x6cm with rt ureter compression Rt Post OP 2 months No hydro -
- 6 LAVH + excision of DIE DIE, endometriosis Lt Post OP D15 No hydro -
- 7 LAVH+BSO Myoma, post wall, 5cm Lt Post OP D1 No hydro -

Photo:

Fig 1: The injured left ureter (red arrow)

Fig 2: Dissect L't ureter to common iliac artery (black arrow) Implant ureter at the light from cystoscopy

Fig 3: Dissect bladder wall layer by layer

Fig 4: Insert the Double J stent from cystoscopy to ureter laparoscopically

Fig 5: Cystoscopy view: Using grasping device to keep ureter 1cm inside bladder

Fig 6: Laparoscopy view: L't ureter was implanted into bladder about 1cm inside bladder

Fig 7: Fix the ureter on the bladder with 3-0 vicryl for 3 stitches (at least)

Fig 8: Laparoscopic modified ureteroneocystostomy was done

Results:

All patient recovered well after ureter repair. No urine retention, hydronephrosis or persistent kidney injury after surgery. No recurrent obstruction or extravasation noted after repair.

Discussion:

Using laparoscopic modified ureteroneocystostomy, we suggested time of surgery can be saved without causing any complications like VUR or urine retention. This procedure was easier to be done than others like modified Politano lead better or psoas hitch. We needed more survey and cases in determining whether VUR was identified after using this methods.

Conclusion:

Early recognition and treatment of ureteral injuries are important to prevent morbidity. Laparoscopic modified ureteroneocystostomy could be considered in lower third ureter injuries.

稿件編號：V15	<p style="text-align: center;">案例報告：薦骨脊韌帶懸吊術後之併發症-臀肌陰道瘻管 Gluteo-vaginal fistula after sacrospinous ligament fixation: A case report</p> <p style="text-align: center;">黃璧蒼<sup>1</sup> 莊斐琪<sup>1</sup> 黃寬慧<sup>1</sup> 周鈺敏<sup>1</sup> 陳文欣<sup>1</sup> 高雄長庚醫院婦產部<sup>1</sup></p>
臨時稿件編號： 0225	
論文發表方式： 影片展示	<p>Introduction</p> <p>Sacrospinous ligament fixation is a efficient surgical intervention for improving the symptoms of uterovaginal prolapse. Major complications following Sacrospinous ligament fixation is uncommon and gluteo-vaginal fistulas are very rare. The primary treatment consists of conservative and surgical interventions. Here, we presented a case who experienced gluteo-vaginal fistula after sacrospinous ligament fixation. The patient provided written informed consent.</p>
論文歸類： 內視鏡	<p>Case</p> <p>A 67-year-old woman received vaginal total hysterectomy, sacrospinous ligament suspension, anterior colporrhaphy and posterior colporrhaphy operation due to uterovaginal prolapse 15 years ago. She then experienced vaginal bleeding, brownish discharge every day for 14 years as well as right buttock pain for 2 years. On examination, atrophic vaginitis with granulation (2x3 cm) over right lateral vaginal cuff were seen. Silver nitrate (AgNO<sub>3</sub>) and local estrogen treatment with Premarin cream for 10 months were applied but only improved a little. Wound debridement was arranged and a vaginal-retroperitoneal fistula over upper 1/3 right posterior vaginal wall was found. Pelvic magnetic resonance imaging favored a fistula tract (6x2.5x3cm) formation between right posterolateral aspect of remnant vaginal to medial aspect of right gluteus maximus muscle region. We arranged transvaginal fistulectomy with vaginal approach and applied the concept of vaginal natural orifice transluminal endoscopic surgery (vNOTES) assisted due to hard approach of the deep fistula tract. Dissection and identification of the fistula tract was performed with transvaginal method initially. Nevertheless, the fistula tract was too deep, narrow and hard approaching. As a result, we applied the concept of vaginal natural orifice transluminal endoscopic surgery (vNOTES) with the use of glove port, 30 degree endoscopy and endoscopic instruments such as energy device (THUNDERBEAT handpieces). Two ETHIBOND EXCEL suture stiches, which are nonabsorbable, braided, composed of Poly (ethylene terephthalate), were found at right sacrospinous ligament. The entire fistula tract were removed successfully. Histopathological report was consistent with the diagnosis of fistula. The patient recovered well and was symptoms-free during the follow-up period for more than one year.</p> <p>Conclusions</p> <p>The managements of gluteo-vaginal fistula after sacrospinous ligament fixation depend on the clinical conditions and could be challenging. We suggested that removal of the fistula tract and reconstruction of the layer should be considered if conservative treatments fail. If the operation field is narrow, deep and hard approaching, we advised to apply the concept of vaginal natural orifice transluminal endoscopic surgery (vNOTES) with the use of glove port, 30 degree endoscopy and endoscopic instruments such as energy device.</p>