

稿件編號：V15	<p style="text-align: center;">腹腔鏡分期手術進行後腹腔淋巴腺廓清時偶然發現重複輸尿管 Incidental finding of duplicated ureter during laparoscopic retroperitoneal lymph nodes dissection</p> <p>謝耀德¹ 王功亮² 陳楨瑞¹ 馬偕紀念醫院婦產部¹ 台東馬偕醫院²</p>
臨時稿件編號：0392	
論文發表方式：影片展示	<p>Introduction: Duplicated ureter is the most common renal abnormality, occurring in approximately 1% of the population. It occurs in about 0.7% of healthy adults. Duplicated ureter is more common in White Americans than in African-Americans. Female is more common than male.</p>
論文歸類：內視鏡	<p>Case Report: This 49 year-old, sex(-), female was diagnosed to be endometrial endometrioid carcinoma, grade 2, after diagnostic D&C. Laparoscopic staging procedure was carried out after well explanation. During left pelvic lymph nodes dissection, duplicated ureter was identified incidentally after developing the retroperitoneal space. Because of adenomyosis and pelvic endometriosis, duplicated ureter was dissected to the ureter tunnel for preventing inadvertent damage during electro-sealing of uterine vessels. Staging procedure was completed laparoscopically without any complication.</p> <p>Conclusion: Although duplicated ureter is not a rare clinical condition, it is rarely showed and recorded during laparoscopic surgery. Before starting retroperitoneal lymph nodes dissection, accurate space development and vital structures identification should be the most important way to complete the surgery successfully.</p>

稿件編號：V16	<p>因 COVID-19 疫情導致延宕及困難診斷的卵巢克魯根勃氏瘤: 使用諧波刀同時進行胃癌及卵巢腫瘤切除術案例報告</p>
臨時稿件編號：0464	<p>Delay or difficult diagnosis of Krukenburg tumor during COVID-19 pandemic - Simultaneous gastric and ovarian cancer surgery with harmonic scalpel</p> <p>王孝棻¹ 莊乙真¹ 吳建明² 劉馨鎂¹ 盧信芬¹ 亞東醫院婦產部¹ 亞東醫院外科部²</p>
論文發表方式：影片展示	<p>A 40-year-old female was found to have left 8 cm ovarian tumor at local clinic health check-up. She had no body weight loss, loss of appetite, abdominal distension, no major surgery before. The gynecology ultrasound revealed a 8x6 cm ovarian tumor with homogenous, picture, no obvious solid part, no low pressure blood flow. The CA125 was 110 IU/ml. She was scheduled for a laparoscopic cystectomy or oophorectomy at mid May 2021. Due to outbreak of covid-19 at Taiwan, she disappeared for 3 months till August, when another ultrasound revealed the left ovarian tumor 5x5 cm, she was hesitated though but eventually received laparoscopic surgery at Sep 2021.</p>
論文歸類：內視鏡	<p>During surgery, the whole ovarian tumor was put in an endo-bag before trying to enucleation, the internal hard characteristic of ovarian tumor made the surgeon do the unilateral oophorectomy and sent to frozen section, the gross appearance of right ovary is normal.</p> <p>The frozen section revealed metastatic signet ring cell ovarian tumor. The surgery stopped.</p> <p>Upper and lower G-I scopy and CT scan of whole abdomen were done. Only mild gastric erosion found but the gastric biopsy revealed the same signet ring cell type. The CT scan revealed no obvious abdominal lesion or LN enlargement.</p> <p>2 weeks later, simultaneously right oophorectomy and gastric cancer staging was done. A final pathology revealed gastric cancer, pT1bN3bM1, stage IV. The patient was referred to medical oncology for further chemotherapy.</p>

稿件編號：V17	<p style="text-align: center;">腹腔鏡處理巨大子宮頸肌瘤併子宮內頸變形的手術技巧 Laparoscopic management for large cervical myoma with cervix distorsion</p>
臨時稿件編號： 0651	
論文發表方式： 影片展示	<p>Background: Large cervical myoma possesses special surgical difficulties. First, the proximity to adjacent organs (bladder, ureter, uterine vessels, and rectum) makes surgical field exposure difficult and sometimes dangerous. Second, during the myometrium repair stage, the cervical canal and cervical structure may be distorted and become occluded. In this video, we will demonstrate the tips and tricks for laparoscopic management for large cervical myoma.</p>
論文歸類： 內視鏡	<p>Materials & Methods: Video review of some cases with large cervical myoma undergoing laparoscopic myomectomy</p> <p>Results: Before myomectomy for large cervical myoma, the overlying peritoneum should be opened. Bladder flap should be mobilized (for anterior cervical myoma), and the course of ureter and uterine vessels should be carefully traced (for lateral low cervical myoma). The myoma “capsule” was maximally preserved, to facilitate more secure suture for both anatomical restoration and good hemostasis. A large Foley catheter should be put inside the cervical canal before suturing the cervical stroma, to prevent inadvertent incorporation of the cervical canal during the reconstruction process. If the cervical canal was disrupted after myomectomy and the proximal end cannot be identified, then hysterotomy can be performed over the fundal region, exposing the uterine cavity, and we can introduce a grasper antegradely to pull the Foley catheter tip into the uterine cavity. The disrupted cervical canal can then be re-connected and re-constructed.</p> <p>Conclusions: Laparoscopic myomectomy is feasible for large cervical myoma. By careful and thorough dissection, and putting a Foley catheter inside the cervical canal, the cervical stroma can be safely reconstructed without the risk of cervical canal distorsion or occlusion.</p>

稿件編號：V18	<p style="text-align: center;">利用 ICG 來輔助進行術中輸尿管辨認與保留 ICG assisted ureter identification during difficult retroperitoneal dissection</p>
臨時稿件編號： 0660	
論文發表方式： 影片展示	<p>Background: Identification and protection of pelvic ureter is the basic step of advanced gynecologic surgery. However, in some situation (for example, dense retroperitoneal fibrosis from previous surgery or endometriosis, previous hysterectomy or large pelvic tumor causing anatomy alteration, severe pelvic adhesion.....), ureter identification and ureterolysis may be very difficult. Besides, during the ureterolysis procedure, the bleeding control around or nearby the ureter become hazardous because of the potential thermal injury to the pelvic ureter. Traditionally, large area retroperitoneal dissection is necessary to achieve adequate anatomical exposure and safe hemostasis with energy device. In this video, we will demonstrate the usage of ICG to simplify identification of pelvic ureter.</p> <p>Materials & Methods: Setting: single hospital Video system: Storz TIPCAM 1 Rubina 4K-3D-NIR/ICG videoendoscope. Surgical videos review.</p> <p>Results: Cystoscopy was performed first before the laparoscopic procedure. Ureter orifice was identified, and single J catheter was introduced into pelvic ureter, advanced up to renal calyx or at least 15 cm upward. ICG was then injected into the ureter. Under laparoscopy, the ICG-stained pelvic ureter can be easily identified, and can be easily traced. The ureterolysis became easier, faster, without the need for advanced retroperitoneal dissection to confidently clarify the course of pelvic ureter, which will induced more bleeding. With the aid of ICG staining, hemostasis can be more easily achieved with less chance of thermal injury to pelvic ureter.</p> <p>Conclusions: Ureteroscopic or cystoscopic ICG injection into pelvic ureter can be very helpful for identification and preservation for pelvic ureter, especially in those cases with dense retroperitoneal scarring.</p>
論文歸類： 內視鏡	

稿件編號：V19	<p>針對大子宮之結合袋內手切碎瘤法的單孔腹腔鏡次全子宮切除術 Contained manual morcellation techniques of large uterus in laparo-endoscopic single-site subtotal hysterectomy.</p>
臨時稿件編號：0456	
論文發表方式：影片展示	<p>張婷瑜¹ 桂羅利¹ 張基昌¹ 張裕¹ 義大醫院婦產部¹</p>
論文歸類：內視鏡	<p>Introduction According to FDA's estimate, 1 in 352 women receiving hysterectomy or myomectomy for the treatment of myomas has in fact an unsuspected uterine sarcoma. After against power morcellation in 2014, the FDA recommends performing containment system in women when laparoscopic power morcellation is appropriate in 2020. The containment system is intended to isolate specimen, which may prevent the peritoneal spread of cancerous tissue, endometriosis or parasitic myomas. In this video, we demonstrate contained manual morcellation techniques of large uterus in single-port laparoscopic gynecologic surgeries.</p> <p>Case report This 52 y/o women, G3P2AA1, with an ultrasonographic feature of enlarged uterus (diameter to 15 cm), had menorrhagia for 3 years leading to chronic anemia. She received laparo-endoscopic single-site subtotal hysterectomy and bilateral salpingectomy. We used a secure containment bag (Alexis Contained Extraction system) for excised tissue and performed manual extraction through umbilicus incision site. The uterine weight was 613.5 g. The total manual morcellation time was 17 mins. The final pathology report was leiomyoma and adenomyosis.</p> <p>Discussion In this case, though she had no known or suspected gynecological malignancy (by preoperative image, tumor marker and cervix cytology report), the risk of occult cancer increases with age, particularly in women over 50 years of age. Therefore, it is reasonable to performed in-bag morcellation. The required technique was to place large specimen into contained system by single port setting, not to make bag rupture while we manually extracted the contained tissue with scalpel through the 2.5-cm incision wound. We regard contained manual morcellation is a reliable option and can be applied wisely in laparoscopic subtotal hysterectomy.</p>

稿件編號：V20	<p style="text-align: center;">剖腹產後切口疝氣經減孔腹腔鏡修復之病例報告</p> <p style="text-align: center;">A case report of previous Cesarean section incisional hernia, managed by reduced port surgery</p> <p>張雅婷¹ 桂羅利¹ 義大醫院婦產部¹</p>
臨時稿件編號：0488	
論文發表方式：影片展示	<p>Ventral hernia is common after abdominal surgeries where incisional hernia occurs in approximately 10-15% of patients with a previous abdominal incision surgery. Open repair was the traditional method for management. Yet, due to laparoscopic surgeries thriving in recent years, laparoscopic repair of ventral incisional hernia has been performed successfully with evidence of shortened hospital stay and reduced recurrent rates. Despite the commonness of post-operative hernia, incisional hernia post ceserean section is rather rare with an incidence of 0.2%. Here, we present a rare case with omentum trapped in incisional hernia at the previous Cesarean section wound accidentally found during a laparoscopic assisted total hysterectomy operation, managed by releasing the trapped omentum and repair the abdominal wall with laparoscopic extracorporeal knots method.</p>
論文歸類：內視鏡	

稿件編號：V21	<p style="text-align: center;">單孔腹腔鏡應用於單側巨大雙畸胎瘤之影片演示 Laparoendoscopic single-site (LESS) ovarian cystectomy of two mature cystic huge teratomas in one ovary</p> <p>龐浸醛^{1,2} 陳佩辰¹ 花蓮慈濟醫院婦產部¹ 花蓮慈濟醫院微創中心²</p>
臨時稿件編號：0524	
論文發表方式：影片展示	Objective: To present a case of huge ovarian teratoma who received LESS ovarian cystectomy.
論文歸類：內視鏡	<p>Methods and material: The patient was a 23 year old female, a nulliparity, presented with right lower abdominal pain for one month. Transvaginal ultrasound revealed a left ovarian cyst with two compartments and heterogeneous hyperdense density about 9.2*6.5 cm in size. Under the impression of left ovarian teratoma, LESS ovarian cystectomy was done. The difficulties of this case are:1.Two teratoma in a big cyst;2.Single port approach;3.Patient is nulliparous and has fertility needs so we need to preserve as much as possible of her ovarian tissue. Enseal G2 was used in this surgery because of the advantage of blunt dissection. After incision on the serosa of ovary, effective blunt dissection by rolling skill with the tip of Enseal G2, without rupturing the teratoma cyst and avoiding content dissemination to peritoneal cavity.</p> <p>Results: During surgery a big whitish ovarian cyst arising from the left side, about 12x9cm in size. Enucleation was done, on dissection, two compartments were noted and each with yellowish fatty fluid and black hair in content, They were two teratomas. Chromotubation revealed free spillage of Methylene blue from bilateral fimbria.</p> <p>Conclusion: We hope to share the video of the surgery at the coming meeting.</p>

稿件編號：V22	<p style="text-align: center;">腹腔鏡子宮肌腺瘤切除: 改良式四瓣手術 Laparoscopic adenomyomectomy with a modified 4-petal method</p>
臨時稿件編號： 0627	
論文發表方式： 影片展示	<p>Background Adenomyosis accounts for 20 % of reproductive age women and can be treated surgically or medically. Laparoscopic adenomyomectomy with the four-petal method was presented by Kuo et al. in APAGE 2017, which gave the advantages of full exposure to the localized adenomyosis and adequate thickness of the uterine wall after the operation. However, the surgical time spent on suturing on a serosal wound is longer. Therefore, we presented a modified method to shorten the suture time.</p>
論文歸類： 內視鏡	<p>Patient and Methods This is a 42 year-old female, P1, with chief complaints of dysmenorrhea for 7 months. Abdominal sonography showed adenomyoma with 4*5.5cm in size at the posterior wall. Due to the uterus sparing request by the patient, laparoscopic adenomyomectomy with a modified four-petal method was arranged. Laparoscopy was performed with one single port (with one 11mm and 5mm ports) and two acillary 5 mm trocars. An posterior bulge of the uterus was identified and a cruciate incision was made. Adenomyoma was fully exposed and was removed. Dissected myometrium was approximated by 1-0 V-loc suture. To repair the serosal wound, we anchor the right two serosal flaps to the subendometrial tissue first then left two serosal flaps overlapping on the right side two serosal flaps. This modified wound closure method could avoid dead space and more adequate thickness of the uterine wall after operation. The modified 4-petal method is that we skip serosal cruciate wound repair which can save surgical time.</p> <p>Result Adenomyoma was removed. Total surgical time was 2 hours and 10 minutes. Pathology report showed adenomyosis with ectopic island of endometrial gland and stroma . Blood loss was 100 ml. The postoperative course was uncomplicated and the patient was discharged on postoperative day 3.</p> <p>Conclusion We presented a modified 4 petal method mainly changed for the way of wound repair. In conclusion, laparoscopic adenomyomectomy with the modified four-petal method is a feasible and safe procedure and favored for women with uterine sparing requests.</p>

稿件編號：V23	<p>在放置子宮內投藥系統下利用子宮鏡碎瘤器治療子宮內膜增生的訣竅 Tips and tricks of using hysteroscopic morcellation for treatment of endometrial hyperplasia with Mirena in situ</p>
臨時稿件編號：0662	
論文發表方式： 影片展示	<p>王祉茵¹ 桂羅利¹ 張基昌¹ 張裕¹ 義大醫院婦產科¹</p>
論文歸類： 內視鏡	<p>Introduction Mirena (levonorgestrel intrauterine systems) are used for treatment of menorrhagia or endometrial hyperplasia. Hysteroscopy is the gold standard for evaluation of endometrium.</p> <p>Case report We present a 41-year-old female patient, Gravida 3 and Para 2 (Cesarean delivery), with abnormal uterine bleeding. Hysteroscopic surgery was performed, and pathology report revealed complex atypical hyperplasia. Further treatment was insertion of Mirena. Follow-up hysteroscopy showed persistent endometrial hyperplasia. We arranged hysteroscopic morcellation for treatment of endometrial hyperplasia with inserted Mirena.</p> <p>Discussion After placing Mirena for therapeutic purpose, regular supervision of the endometrium is needed. However, physicians often encountered difficulties while performing endometrial biopsy with inserted Mirena. In our case with persistent endometrial hyperplasia and Mirena, we used hysteroscopic morcellation for endometrial shaving successfully.</p>