

## VIDEO PRESENTATIONS

### **V01 Treatment and diagnosis of uterine adenomyoma**

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Introduction: An adenomyoma is a benign tumor composed of smooth muscle cells and endometriotic tissue, typically originating within the uterus. Methods: These patients usually present with monthly pain due to embedded blood in the adenomyotic cyst. Results: Diagnosis is established on transvaginal ultrasound and this also will guide you choosing the correct management approach. This video shows ultrasound pictures and present hysteroscopic, and laparoscopic treatment of the problem. Conclusion: Adenomyoma uteri is rare, however ultrasound detect the clinical situation and guide the endoscopic approach.

### **V02 Vaginal synthetic mesh operation for anterior vaginal wall prolapse**

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Objective: It is well-known that the recurrence rate following anterior vaginal wall prolapse is 20-40%. Since synthetic mesh may provide a lower recurrence rate consequently a Nordic multicenter randomized study has been undertaken in order to evaluate the recurrence rate and acceptability of a conventional anterior repair compared to implantation of a synthetic mesh (Avaulta Plus®). All patients are followed for three years with clinical examinations and standardized questionnaires. The present video demonstrates the new procedure for anterior vaginal prolapse with implantation of the mesh. Subjects: In total 150 patients are allocated to either anterior repair or implantation of Avaulta Plus® mesh. Exclusion criteria is previous vaginal surgery and prolapse of the uterus more than stage 2 Results: The present video demonstrates each step in the procedure including injection of local anaesthesia, dissection of the bladder from the anterior vaginal wall mucosae, further dissection close to arcus tendineus to the spine and insertion of the mesh using trocars. Conclusion: The procedure is safe and easy to perform. This new mesh technique will for the first time be assessed in a clinical controlled study in order to evaluate the recurrence rate and quality of life using standardized questionnaires

### **V03 Laparoscopic hysterectomy: experiences from Roskilde**

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Laparoscopic hysterectomy is a minimally invasive procedure, but nevertheless performed in only 6 percent of all patients undergoing hysterectomy. In Roskilde, this percentage is significantly higher. We perform approximately 100 laparoscopic hysterectomies per year, constituting one third of all hysterectomies in Roskilde and 39 percent of all laparoscopic hysterectomies in Denmark. The procedure involves a complete laparoscopic separation of the uterus from its vessel and ligaments and removal of the uterus through the vaginal route (see video). DHD data from the last 2 years show that 90 percent of the uteri had a weight of less than 300 gram. Bleeding complications were rare, ranging between 3 and 6 percent.. Only 1 percent underwent a reoperation. Most patients were dismissed either the same day or the day after the operation. In recognition of this we have initiated a project where laparoscopic hysterectomy is performed on an outpatient basis. Preliminary data suggest that outpatient management is possible without loss of patient satisfaction or clinical outcome. In conclusion, our experiences show that laparoscopic hysterectomy is a safe procedure with few complications and rapid postoperative recovery.

## **V04 Laparoscopic hysterectomy and lymphadenectomy in patients with endometrial cancer**

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Objective: To describe the laparoscopic total hysterectomy procedure without the use of uterine manipulator and concomitant pelvic lymphadenectomy Subject and Methods: All patients with more than 50% myometrial invasion and without involvement of the cervix are scheduled for laparoscopic total hysterectomy and lymphadenectomy. The Ethicon Harmonic Scalpel was used for the procedure. The steps were as follows: 1) Division of the ovarian artery and vein followed by incision of the peritoneum thereby being able to dissect the bladder from the cervix and division of the sacro-uterine ligament posterior. 2) Identification and division of the uterine artery and vein followed by incision of the cardinal ligament. 3) Opening the vagina and removal of the uterus followed by suturing of the vaginal cuff. 4) Incision of the peritoneum laterally to the umbilical ligament and parallel to the external iliac artery. 5) Identification of the common iliac artery and vein bifurcation as well as ureter. 6) Identification of the genitofemoral nerve. 7) Removal of the fatty tissue overlying the external and internal artery and vein. After identification of the obturator nerve, the fatty tissue is removed from the lateral pelvic wall en bloc. Results: In average 18 pelvic lymphnodes are removed. The average operation time is 90 minutes and the patient stay in hospital is in average one day after the surgery. All patients had a sick leave for 14 days. Conclusion: The video describes each step in the procedure which is safe and relatively easy to perform.