

The objective of this video is to demonstrate a systematic, step-wise approach to performing a Laparoscopic Hysterectomy, in order to give surgeons of all skill sets, a standardized method to complete a Laparoscopic Hysterectomy in a safe and efficient manner.

Moving surgeons away from using the same procedural steps as an abdominal approach is key to giving surgeons a technique to successfully perform a Laparoscopic Hysterectomy.

**292 Video Session 10 – Basic Science, Research & Education**  
(3:25 PM - 5:05 PM)

4:18 PM – GROUP B

**Uterosacral Ligament Colposuspension After Laparoscopic Hysterectomy: A Procedure We Should All Be Able to Offer Our Patients**

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Both General and Oncologic Gynecologists are called upon to address prolapse issues during hysterectomy for benign or malignant indications. The technique for Uterosacral Ligament (USL) Colposuspension is best begun by placement of permanent sutures 3 cm from the cervix, through each of the USL's, while tented up by the intact uterus, after visualizing the ureters. Then, after the hysterectomy and vaginal closure are complete, these sutures are tensed, delineating the more distal USL for permanent suture placement 1.5 cm from the cervix, which is then passed through the posterior and then anterior pubocervical fascia on each side and tied. Finally, the original sutures placed 3 cm from the cervix are passed through the more medial posterior and anterior vaginal fascia, and tied, lifting the vaginal apex. Cystoscopy is then performed to confirm ureteral patency.

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4:29 PM – GROUP C

**Transient Uterine Devascularization for a Missed Abortion with Complete Placenta Previa on a Second Trimester Dilatation and Evacuation**

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Placenta previa has been on a rise in the recent years to the increased amount of cesarean sections. Placenta previa and sometimes even placenta accreta can be encountered in special situations. We present a case in need of a Dilatation and Evacuation due to Missed Abortion at 23 weeks and due to Trisomy 21. The pregnancy was complicated by complete placenta previa. A transient uterine devascularization was performed via the laparoscopic route. An estimated blood loss of only 100 cc was encountered during the Dilatation and evacuation.

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4:36 PM – GROUP C

**Pelvic Vessels Anatomy: What Netter Doesn't Show**

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The purpose of the video is to demonstrate pelvic vessels anatomy including deep uterine vessels. Deep uterine vessels are often not pictured in textbooks or atlases. They are typically not isolated during benign gynecologic procedures or Wertheim type radical hysterectomy. The author has completed his gynecologic oncology fellowship never seeing deep uterine vessels.

Although most gynecologists will not encounter deep uterine vessels during their surgeries, it appears prudent that blood supply to the uterus is be fully understood by all pelvic surgeons.

The video demonstrates pelvic vessels anatomy during nerve-sparing robotic radical hysterectomy. Vessels distal to common iliac artery and vein are dissected, isolated and labeled to enhance tutorial. Diagrams are used. Elements of robotic dissection technique are discussed and demonstrated.

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4:43 PM – GROUP C

**Vasopressin in Gynecological Procedures**

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Vasopressin is commonly used in numerous routine gynecological procedures in order to decrease blood loss. This video reviews its basic physiology, dosage, potential complications and administration. Furthermore, clinical scenarios where the use of vasopressin can be beneficial are demonstrated. These include hysteroscopic/laparoscopic myomectomies, laparoscopic cystectomies as well as laparoscopic managements of ectopic pregnancies (tubal, interstitial and caesarean scar pregnancies). Different vasopressin injection techniques are also explained throughout this video. In conclusion, not only does the use of vasopressin in gynecological surgeries decrease blood loss but it also helps in delineating surgical planes, and improves surgical visualizations.

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**Laparoscopic Training Using the Human "Mirror Neuron System"**

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When performing a surgery is not possible, can physicians still improve their technique by observing the surgery, watching a video, or imitating the surgery? This study was conducted to determine whether observation and imitation are effective training methods. Fifteen physicians who had never experienced laparoscopic surgery were randomly distributed into three groups: control, watching video, and performing air surgery. Each physician practiced performing five sets. In the control group, the total time was significantly shortened in the 2nd set. The time did not change significantly after the 2nd set. In the video group, the time shortened steadily each time. In the air surgery group, the time was shortened, despite the absence of physical objects. Through the use of the mirror neuron system, which is built-in genetically in primates, a variety of skills can be developed, even when performing the actual surgery is not possible.

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**Posterior Obliterated Cul-de-Sac Model: A Feasibility Study**

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