

the pelvic brim, a supernumerary ovary, vaginal agenesis, and an ectopic ureter arising from her urethra.

Interventions: Patient chronic pain worsened during her evaluation and she was referred to minimally invasive gynecologic surgery specialists for surgical management including supracervical hysterectomy and removal of the rudimentary horn along with ipsilateral ovaries and fallopian tubes. Her vaginal agenesis required manual morcellation in a containment bag and her abnormal urinary tract anatomy required pre-operative ureteral stenting.

Measurements/Results: Results to be presented.

Conclusions: Safe hysterectomy in a patient with multiple anomalies of the reproductive and urogenital tracts requires extensive evaluation of abnormal anatomy using imaging and diagnostic procedures. Surgery should be approached with caution and the operation undertaken should be appropriate to the indication. In this case, the patient's pain was unresponsive to medical management and her fertility was no longer a priority for her. Operative planning should include thoughtful consideration of number and placement of operative ports, pre-operative stents when needed, appropriate equipment and procedure for morcellation, and advanced surgical techniques to carefully identify retroperitoneal structures.

466 Virtual Poster Session 2 (1:20 PM – 2:35 PM)

1:40 PM – STATION K

Cesarean Scar Pregnancies: Systematic Review and Laparoscopic Approach

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Objective: Cesarean scar pregnancies have become more common in the last decades. Occurrence is 1 in 500 pregnancies among women with previous cesarean delivery and account for 4% of ectopic pregnancies. Many treatment options have been reported in the literature and we performed in 2017 a systematic review, to assess the efficacy and safety of treatment options for cesarean scar pregnancies. This video presents a review of the management of the cesarean scar pregnancy (CSP) and tips and tricks for excision and repair of the defect by laparoscopy.

Design: A review and a case report.

Settings: A university hospital.

Patients: We present the case of a 31 year old woman with no past medical or surgical history except a low transverse caesarean section at term for her first child. She became pregnant 10 months after her caesarian section and presented first trimester bleeding. CSP was diagnosed on transvaginal ultrasound by visualizing the gestational sac in the myometrium at the scar site and systemic injection of MTX was initially performed. Two months after the injection, HCG was negative but the patient presented with persistent bleeding. On ultrasound, a 23x26x20 mm outward bulge was visualized. A type 2 CSP was diagnosed and hysteroscopic resection was judged inappropriate.

Interventions: An excision of CSP and repair of the defect by laparoscopy was performed.

Measurements/Results: Results to be presented.

Conclusions: Excision and repair is often required for type 2 CSP with laparoscopy allowing for a minimally invasive approach. Such repair permits a correction of the scar defect with potential advantages for subsequent pregnancies.

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1:40 PM – STATION L

"T Shape" Suture to Avoid Ureteral Kinking in Bladder Endometriosis Surgery: A Case Report

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Objective: A case report that describes the "T shape" suture, a specific surgical technique for bladder closure, after the removal of a big endometriotic nodule in the bladder trigone.

Design: Video article.

Settings: Academic and public tertiary hospital in São Paulo, Brazil.

Patients: A 35-year-old nulliparous woman came to our service for progressive dysmenorrhea, dyspareunia, hematuria, pain to urinate and repetitive urinary tract infection without resolution with dienogest. Examinations showed a 6 centimeter bladder nodule in the inferior wall, neighboring both ureters, without hydronephrosis, and endometriotic lesions in the deep posterior compartment.

Interventions: The patient underwent laparoscopic surgery for endometriotic lesion resection. The big bladder nodule was fully resected using ultrasonic energy after dissection and isolation, resulting in the resemblance of an inverted "V" image in the bladder. Aiming to use a suture with less influence on bladder capacity and the ureteral path, it was decided to perform a "T shape" suture, beginning in the apex of the reversed "V", with continuous suture until matching the edge. Once a symmetrical horizontal image of the incision was achieved, a continuous horizontal suture was performed. All visible endometriotic lesions were resected during the procedure.

Measurements/Results: Following the surgery, the patient had good bladder drainage up to 10 days and no urinary complaints.

Conclusions: "T shape" suture on the bladder seems to prevent reduction of bladder capacity and avoid ureteral kinking post operatively. Further studies are necessary to confirm our clinical impression.

468 Virtual Poster Session 2 (1:20 PM – 2:35 PM)

1:40 PM – STATION M

The Safety of Incidental Appendectomy at the Time of Total Laparoscopic Hysterectomy

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Objective: To determine if incidental appendectomy performed at the time of total laparoscopic hysterectomy (TLH) increases surgical duration or complications.

Design: Retrospective cohort study.

Settings: Four academic affiliated and community-based hospitals.

Patients: Patients undergoing laparoscopic hysterectomies performed by a single surgeon from September 5, 1996 to April 21, 2016.

Interventions: Addition of incidental appendectomy at the time of TLH.

Measurements/Results: A total of 2,141 TLHs were identified. After excluding cases with other lengthy procedures (node dissections, cholecystectomy), 1524 cases were analyzed and able to be matched by age, body mass index (BMI) and parity, for comparison, yielding 762 who did not have appendectomy, 762 had appendectomy. The mean duration of surgery with appendectomy was shorter, (112 vs. 130 minutes, $p < .001$); estimated blood loss was less (123 vs. 142 mL, $p = .04$) and transfusions were similar (0.04/case, $p = .259$). Infectious complications were fewer (1.1% vs. 2.2%, $p = .042$), re-operations were fewer (1.8% vs. 4.4%, $p < .001$) and hospital stays were shorter (1.1 vs. 1.3 days, $p < .001$).

Conclusions: Incidental appendectomy during laparoscopic hysterectomy appears safe and feasible.